		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: 0046011

Facility Name: Prairie Manor Nrsg Rehab Ctr

Address: 345 Dixie Highway (Number) Chicago Heights (City) 60411 (Zip Code)

County: Cook

Telephone Number: (708) 754-7601 **Fax #** (708) 754-8904

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2002

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 to 12/31/20 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)
* *Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	148	Skilled (SNF)	148	54,168	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	148	TOTALS	148	54,168	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	26,068	2,324	10,443	38,835	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,068	2,324	10,443	38,835	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.69%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/1/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 148 and days of care provided 9,218

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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	408,842	59,586	46,998	515,426		515,426	686	516,112			1
2	Food Purchase		244,440		244,440		244,440	(51)	244,389			2
3	Housekeeping	412,970	69,669		482,639		482,639	1,258	483,897			3
4	Laundry	150,359	13,802		164,161		164,161		164,161			4
5	Heat and Other Utilities			270,010	270,010		270,010	(32,365)	237,645			5
6	Maintenance	96,902		233,702	330,604		330,604	(8,612)	321,992			6
7	Other (specify):*							3,425	3,425			7
8	TOTAL General Services	1,069,073	387,497	550,710	2,007,280		2,007,280	(35,659)	1,971,621			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	3,728,665	350,800	63,890	4,143,355		4,143,355	8,118	4,151,473			10
10a	Therapy	101,306		1,523	102,829		102,829		102,829			10a
11	Activities	238,582	10,435		249,017		249,017		249,017			11
12	Social Services	237,708			237,708		237,708	14,680	252,388			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,814	6,814			15
16	TOTAL Health Care and Programs	4,306,261	361,235	99,913	4,767,409		4,767,409	29,612	4,797,021			16
	C. General Administration											
17	Administrative	187,919			187,919		187,919	109,381	297,300			17
18	Directors Fees											18
19	Professional Services			644,446	644,446	(20,994)	623,452	(508,581)	114,872			19
20	Dues, Fees, Subscriptions & Promotions			151,326	151,326		151,326	(26,419)	124,907			20
21	Clerical & General Office Expenses	244,851	31,145	366,032	642,028		642,028	(154,275)	487,753			21
22	Employee Benefits & Payroll Taxes			990,644	990,644		990,644	(1,991)	988,653			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,668	2,668		2,668	704	3,372			24
25	Other Admin. Staff Transportation			582	582		582	636	1,218			25
26	Insurance-Prop.Liab.Malpractice			464,309	464,309		464,309	1,742	466,051			26
27	Other (specify):*							43,974	43,974			27
28	TOTAL General Administration	432,770	31,145	2,620,007	3,083,922	(20,994)	3,062,928	(534,829)	2,528,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,808,104	779,877	3,270,630	9,858,611	(20,994)	9,837,617	(540,875)	9,296,742			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 Manor Nrsg Rehab Ctr #0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			129,339	129,339		129,339	128,935	258,274			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			455	455		455	177,988	178,443			32
33	Real Estate Taxes			765,212	765,212	20,994	786,206	4,813	791,019			33
34	Rent-Facility & Grounds			492,000	492,000		492,000	(492,000)				34
35	Rent-Equipment & Vehicles			12,396	12,396		12,396	233	12,629			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,399,402	1,399,402	20,994	1,420,396	(180,031)	1,240,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		372,344	1,117,969	1,490,313		1,490,313	(29,291)	1,461,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,142	269,142		269,142		269,142			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		372,344	1,387,111	1,759,455		1,759,455	(29,291)	1,730,164			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,808,104	1,152,221	6,057,143	13,017,468		13,017,468	(750,198)	12,267,270			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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(33,726)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(52,557)	30		9
10	Interest and Other Investment Income	(70,729)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(304,084)	21		24
25	Fund Raising, Advertising and Promotional	(17,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(67,013)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (546,286)		$	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)	(203,912)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,912)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (750,198)		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 Manor Nrsg Rehab Ctr

ID# 0046011

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (7,677)	21	1
2	Theft Loss	(1,963)	21	2
3	Collection Expense	(9,407)	21	3
4	Building Co. - Management Fees	(7,300)	21	4
5	Building Co. - Filing Fee	(75)	20	5
6	Building Co. - Amortization	(5,034)	36	6
7	R/E Tax Bank Convenience Fee	(12)	33	7
8	Capitalized R&M	(22,875)	06	8
9	PAC Dues	(11,528)	20	9
10	Legal Expense	2,009	19	10
11	Bank Fees	(30)	21	11
12	Duplicate Expense	(3,120)	21	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**	(67,013)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Prairie Manor Nrsg Rehab Ctr

IDF 00466511

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			127	559								686	1
2	Food Purchase	(144)		93									(51)	2
3	Housekeeping			1,110	148								1,258	3
4	Laundry													4
5	Heat and Other Utilities	(33,726)		1,215	146								(32,365)	5
6	Maintenance	(22,875)		14,116	147								(8,612)	6
7	Other (specify):*			3,343	82								3,425	7
8	**TOTAL General Services**	(56,745)		20,004	1,082								(35,659)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				32,504	(22,200)	(2,185)						8,118	10
10a	Therapy													10a
11	Activities													11
12	Social Services				14,680								14,680	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,814								6,814	15
16	**TOTAL Health Care and Programs**				53,998	(22,200)	(2,185)						29,612	16
	C. General Administration													
17	Administrative			15,891	93,490								109,381	17
18	Directors Fees													18
19	Professional Services	2,009		(383,229)	(127,360)								(508,581)	19
20	Fees, Subscriptions & Promotions	(29,636)	75	2,069	1,073								(26,419)	20
21	Clerical & General Office Expenses	(333,581)	7,300	123,243	48,824		(61)						(154,275)	21
22	Employee Benefits & Payroll Taxes			(1,991)									(1,991)	22
23	Inservice Training & Education													23
24	Travel and Seminar			337	367								704	24
25	Other Admin. Staff Transportation			636									636	25
26	Insurance-Prop.Liab.Malpractice			1,364	378								1,742	26
27	Other (specify):*			23,387	20,587								43,974	27
28	**TOTAL General Administration**	(361,209)	7,375	(218,293)	37,359		(61)						(534,829)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(417,954)	7,375	(198,289)	92,439	(22,200)	(2,247)						(540,875)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(52,557)	179,218	2,139	135								128,935	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(70,729)	240,947	7,647	123								177,988	32
33	Real Estate Taxes	(12)		4,256	569								4,813	33
34	Rent-Facility & Grounds		(492,000)										(492,000)	34
35	Rent-Equipment & Vehicles			233									233	35
36	Other (specify):*	(5,034)	5,034											36
37	TOTAL Ownership	(128,332)	(66,801)	14,275	827								(180,031)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(29,291)						(29,291)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(29,291)						(29,291)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(546,286)	(59,426)	(184,014)	93,266	(22,200)	(31,538)						(750,198)	45

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	34	Rent	$ 492,000	Prairie Manor Property, LLC		$	$ (492,000)	1
2	V	33	Real Estate Taxes	765,212	Prairie Manor Property, LLC		765,212		2
3	V	32	Interest	345	Prairie Manor Property, LLC		241,292	240,947	3
4	V	21	Management Fees		Prairie Manor Property, LLC		7,300	7,300	4
5	V	20	Filing Fee		Prairie Manor Property, LLC		75	75	5
6	V	30	Depreciation		Prairie Manor Property, LLC		179,218	179,218	6
7	V	36	Amortization		Prairie Manor Property, LLC		5,034	5,034	7
8	V				Prairie Manor Property, LLC				8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,257,557			$ 1,198,131	$ * (59,426)	14

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	ADAM VALES ACCUM. TRUST	11.11%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	PRAIRIE MANOR PROPERTY	CHICAGO HEIGHTS	BUILDING COMPANY	1
2	DANIEL ROTHNER ACCUM. TRUST	11.11%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3	KATHRYN VALES ACCUM. TRUST	11.11%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	KIMBERLY RICHMAN ACCUM. TRUST	11.11%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	MELISSA ROTHNER ACCUM. TRUST	11.11%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	NATHAN & SHIRLEY ROTHNER TRUST	22.22%	ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM. TRUST	11.11%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8	WILLIAM ROTHNER ACCUM. TRUST	11.11%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	01	Dietary	$	Extended Care Consulting, LLC		$ 127	$ 127	15
16	V	02	Food		Extended Care Consulting, LLC		93	93	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,110	1,110	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,215	1,215	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,421	2,421	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	388,176	Extended Care Consulting, LLC		4,947	(383,229)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,069	2,069	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		10,895	10,895	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		337	337	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		636	636	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,364	1,364	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,139	2,139	27
28	V	32	Interest		Extended Care Consulting, LLC		7,647	7,647	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,256	4,256	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		233	233	30
31	V	06	Maintenance Salaries	6,636	Extended Care Consulting, LLC		18,331	11,695	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,343	3,343	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		15,891	15,891	33
34	V	21	Office and Clerical Salaries		Extended Care Consulting, LLC		112,348	112,348	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		23,387	23,387	35
36	V	22	Employee Benefits	1,991	Extended Care Consulting, LLC			(1,991)	36
37	V								37
38	V								38
39	Total			$ 396,803			$ 212,789	$ * (184,014)	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Salary	$	Extended Care Clinical, LLC		$ 559	$ 559	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		148	148	16
17	V	5	Utilities		Extended Care Clinical, LLC		146	146	17
18	V	6	Maintenance		Extended Care Clinical, LLC		147	147	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		82	82	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		31,684	31,684	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		820	820	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		14,680	14,680	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,814	6,814	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		93,490	93,490	25
26	V	19	Professional Fees	129,396	Extended Care Clinical, LLC		1,298	(128,098)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC		738	738	27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,073	1,073	28
29	V	21	Office Salary		Extended Care Clinical, LLC		46,592	46,592	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,232	2,232	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		367	367	31
32	V	26	Insurance		Extended Care Clinical, LLC		378	378	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		20,587	20,587	33
34	V	30	Depreciation		Extended Care Clinical, LLC		135	135	34
35	V	32	Interest		Extended Care Clinical, LLC		123	123	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		569	569	36
37	V								37
38	V								38
39	Total			$ 129,396			$ 222,662	$ * 93,266	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	10	Various Equipment	28,344	Vent Lease LLC		6,144	$ (22,200)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,344			$ 6,144	$ * (22,200)	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	10	Nursing and Medical Records	$ 23,384	MAC Rx, LLC		$ 21,198	$ (2,185)	15
16	V	21	Clerical & General Office Expenses	655	MAC Rx, LLC		594	(61)	16
17	V	39	Ancillary	313,416	MAC Rx, LLC		284,125	(29,291)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 337,455			$ 305,917	$ * (31,538)	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 270,854	$ 270,854	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	270,854	CCS Employee Benefits Group			(270,854)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 270,854			$ 270,854	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0	See Attached	1.35	3.37	Alloc Salary	$ 2,408	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,408		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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,219,947	38	$ 3,992	$	38,835	$ 127	1
2	02	Food	Patient Days	1,219,947	38	2,910		38,835	93	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		38,835	1,110	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		38,835	1,215	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		38,835	2,421	5
6	17	Administrative	Patient Days	1,219,947	38			38,835		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		38,835	4,947	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		38,835	2,069	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		38,835	10,895	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		38,835	337	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		38,835	636	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		38,835	1,364	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		38,835	2,139	13
14	32	Interest	Patient Days	1,219,947	38	240,208		38,835	7,647	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		38,835	4,256	15
16	35	Rent - Equipment	Patient Days	1,219,947	38	7,304		38,835	233	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	38,835	18,331	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		38,835	3,343	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	38,835	15,891	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	38,835	112,348	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		38,835	23,387	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 212,789	25

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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 Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	38,835	$ 559	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		38,835	148	2
3	5	Utilities	Patient Days	603,308	20	2,264		38,835	146	3
4	6	Maintenance	Patient Days	603,308	20	2,283		38,835	147	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		38,835	82	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	38,835	31,684	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		38,835	820	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	38,835	14,680	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		38,835	6,814	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	38,835	93,490	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		38,835	1,298	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220			738	13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		38,835	1,073	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	38,835	46,592	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		38,835	2,232	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		38,835	367	17
18	26	Insurance	Patient Days	603,308	20	5,874		38,835	378	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		38,835	20,587	19
20	30	Depreciation	Patient Days	603,308	20	2,099		38,835	135	20
21	32	Interest	Patient Days	603,308	20	1,914		38,835	123	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		38,835	569	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 222,662	25

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	10	Various Equipment	Direct Allocation						6,144	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,144	25

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 21,198	1
2	21	Clerical & General Office Expens	Direct Allocation						594	2
3	39	Ancillary	Direct Allocation						284,125	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 305,917	25

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 270,854	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 270,854	25

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Providence Bank		X	PPP			$	$			$ 455	1
2	Providence Bank		X	Mortgage				5,158,131			241,292	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,158,131			$ 241,747	9
	B. Non-Facility Related*											
10	Interest Income		X								(70,729)	10
11	Interest Income - Bldg Co.		X								(345)	11
12	Alloc from Extended Care Consulting										7,647	12
13	Alloc from Extended Care Clinical										123	13
14	TOTAL Non-Facility Related						$	$			$ (63,304)	14
15	TOTALS (line 9+line14)						$	$ 5,158,131			$ 178,443	15

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.**	$ 673,274	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.)		$ 706,519	2
3. Under or (over) accrual (line 2 minus line 1).		$ 33,245	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 736,779	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.)		$ 20,994	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 791,018	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	638,430	8
	2016	645,023	9
	2017	613,154	10
	2018	673,274	11
	2019	701,694	12

2020 Accrual = $701,694 x 1.05 = $736,779 (rounded)

Allocated from Extended Care Consulting $4,256

Allocated from Extended Care Clinical $569

	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 Manor Nrsg Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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.	32-17-131-007-0000	Long Term Care Property	$ 701,694.40	$ 701,694.40
2.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 4,256.16
3.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 568.68
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,096,019.78	$ 706,519.24

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nrsg Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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 [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2002	$ 459,864	1
2	Allocated from Care Center Building			20,066	2
3	TOTALS			$ 479,930	3

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	148			1988	$ 4,650,000	$ 179,218	39	$ 119,231	$ (59,987)	$ 2,137,203	4
5				2013	1,609,158		39	41,260	41,260	330,081	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	33,716		20	1,524	1,524	29,545	9
10	Various			2004	215,253		20	8,372	8,372	185,298	10
11	Various			2005	96,468		20	2,222	2,222	86,675	11
12	Various			2006	90,264		20	4,361	4,361	66,604	12
13	Various			2007	56,209		20	2,811	2,811	38,881	13
14	Various			2008	31,219		20	1,482	1,482	23,124	14
15	Various			2009	43,314		20	1,608	1,608	29,617	15
16	Various			2010	44,836		20	2,242	2,242	22,934	16
17	Various			2011	104,287		20	4,971	4,971	51,524	17
18	Various			2012	71,505		20	3,576	3,576	31,388	18
19	Various			2013	64,164		20	3,208	3,208	24,665	19
20	Various			2014	335,986		20	16,801	16,801	112,898	20
21	Various			2015	210,762		20	10,538	10,538	58,025	21
22	Various			2016	25,096		20	1,255	1,255	5,577	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		99,807	1,549		1,549		70,426	68
69	Financial Statement Depreciation			129,339			(129,339)		69
70	TOTAL (lines 4 thru 69)		$ 7,782,044	$ 310,106		$ 227,011	$ (83,095)	$ 3,304,466	70

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,782,044	$ 310,106		$ 227,011	$ (83,095)	$ 3,304,466	1
2	190 Nominal Ton Air-Cooled Compressor	2017	179,872		20	8,994	8,994	35,225	2
3	Paving Parking Lot	2017	123,505		20	6,175	6,175	23,157	3
4	Entrance Awning	2017	3,700		20	185	185	678	4
5	3 Shunt Trip Breakers - Tie To Fire Alarm	2017	3,966		20	198	198	677	5
6	Doors-Locker Room/Housekeeping/Utility/Stairwell	2017	5,381		20	269	269	897	6
7	Fire Dampers	2017	59,859		20	2,993	2,993	9,977	7
8	Fire Guard Ceiling Tiles-Entire Facility-Life Safety Requirements	2017	19,092		20	955	955	3,103	8
9	Hvac-Replace Pneumatic Receiver With Digital Operator	2017	5,111		20	256	256	1,001	9
10	Boiler #2 Pump Replacement	2017	3,383		20	169	169	564	10
11	Fire Alarm Equipment	2017	5,613		20	281	281	959	11
12	Entrance Awning Ceiling Replacement	2017	3,500		20	175	175	642	12
13	Entrance Awning Roof Replacement	2017	13,300		20	665	665	2,438	13
14	Lay-In Fireguard Ceiling Tiles	2018	5,108		20	255	255	766	14
15	Lay-In Fireguard Ceiling Tiles	2018	9,082		20	454	454	1,324	15
16	Fire Alarm Equipment	2018	6,082		20	304	304	836	16
17	4 Shower Stall Drain Replacements	2018	23,800		20	1,190	1,190	2,876	17
18	Doors-Janitor Closet, 1St Flr Tub Room, Room 126, 2Nd Flr Med	2018	6,323		20	316	316	790	18
19	8 Shower Drain Replacements	2018	8,966		20	448	448	971	19
20	Cast Iron Pipr Repair - Ceiling Of Medical Records Rm	2019	2,506		20	125	125	250	20
21	Roof Repairs	2019	2,500		20	125	125	250	21
22	Concrete Walkway Replacement	2019	4,550		20	228	228	228	22
23	Installation Of New Rbi Heat Exchanger	2020	9,610		20	481	481	481	23
24	Hot Water Heater Replacement	2020	13,900		20	695	695	695	24
25	Chiller -Thermostat, Flow Switch Repair	2020	2,723		20	136	136	136	25
26	Roof - Epdm And Metal Repairs	2020	6,000		20	300	300	300	26
27	Thermostat Repair In 5 Resident Rooms	2020	3,722		20	186	186	186	27
28	Installation Of Wood Doors	2020	2,523		20	126	126	126	28
29	Boiler - Install 3" Ball Valve On Cold Feed Line	2020	3,358		20	168	168	168	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	1
2									2
3									3
4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,319,078	$ 310,106		$ 253,862	$ (56,244)	$ 3,394,166	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	24,393	625	35	625		11,441	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,640	169	35	169		2,285	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,259	84	35	84		1,529	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	20,151		20			20,151	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	23,747		20			23,747	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,180		20			1,180	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	213	11	20	11		128	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,043	102	20	102		715	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	336	17	20	17		217	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,326	66	20	66		332	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,300	115	20	115		460	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,054	53	20	53		158	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	397	20	20	20		40	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	106	5	20	5		5	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,692		20			2,692	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,173		20			3,173	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2005	158		20			158	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2009	28	1	20	1		17	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2014	265	13	20	13		93	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2015	45	2	20	2		29	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2016	177	9	20	9		44	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2017	307	15	20	15		61	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2018	141	7	20	7		21	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2019	53	3	20	3		5	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2020	14	1	20	1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 95,198	$ 1,318		$ 1,318	$	$ 68,681	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 95,198	$ 1,318		$ 1,318	$	$ 68,681	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting	2007	146	7	20	7		103	8
9	Allocated from Extended Care Consulting	2009	88	4	20	4		53	9
10	Allocated from Extended Care Consulting	2010	859	43	20	43		472	10
11	Allocated from Extended Care Consulting	2011	309	15	20	15		155	11
12	Allocated from Extended Care Consulting	2012	102	5	20	5		46	12
13	Allocated from Extended Care Consulting	2014	1,412	71	20	71		494	13
14	Allocated from Extended Care Consulting	2016	1,693	85	20	85		423	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 99,807	$ 1,549		$ 1,549	$	$ 70,426	34

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 41,045	$ 726	$ 4,105	$ 3,379	10	$ 27,809	71
72	Current Year Purchases	3,080		308	308	10	308	72
73	Fully Depreciated Assets	1,818,111				10	1,818,111	73
74								74
75	TOTALS	$ 1,862,236	$ 726	$ 4,413	$ 3,687		$ 1,846,227	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		Alloc. Extended Care Clinical	2012	$ 3,307	$	$	$	5	$ 3,307	76
77		Alloc. Extended Care Consulting	2014	811				5	811	77
78										78
79										79
80	TOTALS			$ 4,118	$	$	$		$ 4,118	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)	$ 10,665,361	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 310,831	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,275	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (52,557)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,244,511	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,629 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Prairie Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 425,881	$		$ 425,881	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			176,419			176,419	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			473,656			473,656	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				321,709		321,709	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					42,013	50,635		92,648	13
14	TOTAL			$		$ 1,117,969	$ 372,344		$ 1,490,313	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 Manor Nrsg Rehab Ctr # 0046011 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 205,298	$ 339,023	1
2	Cash-Patient Deposits	50,906	50,906	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,410,119	4,410,119	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,938	158,938	6
7	Other Prepaid Expenses	6,627	6,627	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	9,455,594	9,561,689	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,287,482	$ 14,527,302	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		459,864	13
14	Buildings, at Historical Cost		6,350,541	14
15	Leasehold Improvements, at Historical Cost	1,739,391	1,839,391	15
16	Equipment, at Historical Cost	548,725	1,748,725	16
17	Accumulated Depreciation (book methods)	(1,699,000)	(6,237,462)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		21,393	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 589,116	$ 4,182,452	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,876,598	$ 18,709,754	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,701,119	$ 2,701,120	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,539	45,539	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	388,190	388,190	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,696	13,696	31
32	Accrued Real Estate Taxes(Sch.IX-B)	736,779	736,779	32
33	Accrued Interest Payable		18,053	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,885,323	$ 3,903,377	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,158,131	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,276,507	1,276,507	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,276,507	$ 6,434,638	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,161,830	$ 10,338,015	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,714,768	$ 8,371,739	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,876,598	$ 18,709,754	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,162,695	1
2	Restatements (describe):		2
3	Depreciation	7,195	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,169,890	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,544,878	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)**	$ 2,544,878	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)**	$ 9,714,768	24 *

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

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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	$ 13,106,060	1
2	Discounts and Allowances for all Levels	(4,601,787)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,504,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,483,947	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,483,947	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	467	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,787	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,264	19
20	Radiology and X-Ray	6,502	20
21	Other Medical Services	18,139	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 414,159	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	70,729	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70,729	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,089,238	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,089,238	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,562,346	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,007,280	31
32	Health Care	4,767,409	32
33	General Administration	3,083,922	33
	B. Capital Expense		
34	Ownership	1,399,402	34
	C. Ancillary Expense		
35	Special Cost Centers	1,490,313	35
36	Provider Participation Fee	269,142	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,017,468	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,544,878	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,544,878	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,935,353	44
45	Private Pay - Net Inpatient Revenue	602,456	45
46	Medicare - Net Inpatient Revenue	1,603,388	46
47	Other-(specify) Hospice	194,789	47
48	Other-(specify) Insurance	168,287	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,504,273	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,922	2,193	$ 102,161	$ 46.58	1
2	Assistant Director of Nursing	1,973	2,241	95,173	42.47	2
3	Registered Nurses	8,464	9,183	346,549	37.74	3
4	Licensed Practical Nurses	52,883	58,305	1,859,692	31.90	4
5	CNAs & Orderlies	64,660	72,079	1,215,997	16.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,220	5,784	101,306	17.51	8
9	Activity Director	1,788	1,749	28,193	16.12	9
10	Activity Assistants	12,581	14,294	210,389	14.72	10
11	Social Service Workers	7,740	8,608	237,708	27.61	11
12	Dietician					12
13	Food Service Supervisor	1,845	1,968	51,416	26.13	13
14	Head Cook	5,108	5,719	89,542	15.66	14
15	Cook Helpers/Assistants	16,317	18,068	267,884	14.83	15
16	Dishwashers					16
17	Maintenance Workers	3,774	4,297	96,902	22.55	17
18	Housekeepers	24,683	27,492	412,970	15.02	18
19	Laundry	9,456	10,201	150,359	14.74	19
20	Administrator	1,977	2,244	131,240	58.48	20
21	Assistant Administrator	1,978	2,258	56,679	25.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,379	13,079	244,851	18.72	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	3,175	3,667	72,302	19.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,742	2,026	36,791	18.16	33
34	TOTAL (lines 1 - 33)	238,665	265,454	$ 5,808,104 *	$ 21.88	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	939	$ 46,998	01-03	35
36	Medical Director	Monthly	34,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,530	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	1,523	10a-03	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)	939	$ 91,551		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	62	2,753	10-03	51
52	Certified Nurse Assistants/Aides	1,290	52,607	10-03	52
53	TOTAL (lines 50 - 52)	1,352	$ 55,360		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Stucker	Administrator	0	$ 131,240
Nicole Hampton	Assistant Admin	0	56,679
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,919

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consulting	Home Office Allocation	$ 388,176
Extended Care Clinical	Home Office Allocation	129,396
Marcum LLP	Accounting	26,250
Personnel Planners	Unemployment Tax Consultant	2,085
Propay	Payroll Processing	25,870
National Datacare	Resident Fund Processing	1,510
Achieve Technology	E.H.R. Software	14,801
Ability Network	Medicare Billing	10,158
Pinnacle Quality Insight	Customer Satisfaction	995
Abbey Road Consultants	R/E Tax Assessment	20,980
See Attached	Legal	9,780
See Supplemental Schedule		14,444
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 644,446

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 206,311
Unemployment Compensation Insurance	20,666
FICA Taxes	444,320
Employee Health Insurance	263,159
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	236
Pension Expense	47,312
Other Employee Welfare	6,312
Holiday Expense	337
TOTAL (agree to Schedule V, line 22, col.8)	$ 988,653

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	80,496
Health Care Worker Background Check	
(Indicate # of checks performed 799)	7,528
Patient Background Checks	
Dues & Subscriptions	28,606
Licenses & Fees	3,144
See Supplemental Schedule	3,142
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 124,906

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,668
See Supplemental Schedule	704
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,372

* Attach copy of IMRF notifications

**See instructions.

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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? **Yes**
If YES, give association name and amount. **HCCI - $23,058**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,558** 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. $ **269,142**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

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

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