		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: 0054833

Facility Name: Prairie Oasis

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2018

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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) 05/06/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(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 Oasis # 0054833 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	135	Skilled (SNF)	135	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,410	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			3,550	3,550	8
9	SNF/PED					9
10	ICF	27,511	836	1,187	29,534	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,511	836	4,737	33,084	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.96%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 3,550

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 21/31/2020

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

Facility Name & ID Number Prairie Oasis # 0054833 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	268,162	19,975	10,442	298,579		298,579		298,579			1
2	Food Purchase		158,228		158,228		158,228	(40)	158,188			2
3	Housekeeping	216,510	77,558		294,068		294,068	2,546	296,614			3
4	Laundry	85,136	13,662	2,426	101,224		101,224		101,224			4
5	Heat and Other Utilities			154,783	154,783		154,783	(8,349)	146,434			5
6	Maintenance	80,351	2	79,758	160,111		160,111	(1,320)	158,791			6
7	Other (specify):*							2,180	2,180			7
8	**TOTAL General Services**	650,159	269,425	247,409	1,166,993		1,166,993	(4,983)	1,162,010			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,051,058	196,202	169,315	2,416,575		2,416,575	(110,769)	2,305,806			10
10a	Therapy	68,418			68,418		68,418		68,418			10a
11	Activities	110,543	2,450	1,206	114,199		114,199		114,199			11
12	Social Services	116,010		2,757	118,767		118,767		118,767			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,421	5,421			15
16	**TOTAL Health Care and Programs**	2,346,029	198,652	191,278	2,735,959		2,735,959	(105,348)	2,630,611			16
	C. General Administration											
17	Administrative	106,791		196,667	303,458		303,458	(119,264)	184,194			17
18	Directors Fees											18
19	Professional Services			557,841	557,841	(17,250)	540,591	(438,532)	102,060			19
20	Dues, Fees, Subscriptions & Promotions			51,428	51,428		51,428	(14,134)	37,294			20
21	Clerical & General Office Expenses	86,470		331,599	418,069		418,069	(137,765)	280,304			21
22	Employee Benefits & Payroll Taxes			541,148	541,148		541,148		541,148			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,547	18,547		18,547	624	19,171			24
25	Other Admin. Staff Transportation			458	458		458	4,543	5,001			25
26	Insurance-Prop.Liab.Malpractice			448,006	448,006		448,006	3,573	451,579			26
27	Other (specify):*							38,164	38,164			27
28	**TOTAL General Administration**	193,261		2,145,694	2,338,955	(17,250)	2,321,705	(662,791)	1,658,914			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,189,449	468,077	2,584,381	6,241,907	(17,250)	6,224,657	(773,122)	5,451,535			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 Oasis #0054833 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			4,031	4,031		4,031	388,554	392,585			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,169	6,169		6,169	59,081	65,250			32
33	Real Estate Taxes			483,824	483,824	17,250	501,074	135,375	636,448			33
34	Rent-Facility & Grounds			643,920	643,920		643,920	(292,920)	351,000			34
35	Rent-Equipment & Vehicles			9,498	9,498		9,498		9,498			35
36	Other (specify):*			14,397	14,397		14,397	(14,397)				36
37	**TOTAL Ownership**			1,161,839	1,161,839	17,250	1,179,089	275,692	1,454,781			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	34,808	72,533	516,925	624,266		624,266		624,266			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,441	269,441		269,441		269,441			42
43	Other (specify):*			19,778	19,778		19,778	(19,778)	(0)			43
44	**TOTAL Special Cost Centers**	34,808	72,533	806,144	913,485		913,485	(19,778)	893,707			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,224,257	540,610	4,552,364	8,317,231		8,317,231	(517,208)	7,800,023			45

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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	(9,992)	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	388,554	30		9
10	Interest and Other Investment Income	(8,105)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,653)	21		24
25	Fund Raising, Advertising and Promotional	(1,455)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(535,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (310,339)		$	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)	(206,870)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (206,870)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (517,209)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Prairie Oasis

ID# 0054833

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (18,310)	21	1
2	Sequestration Expense	(64,844)	21	2
3	Miscellaneous Income	(8,957)	21	3
4	Marketing Expense	(1,123)	43	4
5	PAC Dues	(12,816)	20	5
6	Prior Year Miscellaneous Expense	(61,947)	21	6
7	Prior Period Accounting Fees	(10,717)	19	7
8	Amortization	(14,397)	36	8
9	Other Prior Year Professional Fees	(3,441)	19	9
10	Building Co - Dues and Subscriptions	(77)	20	10
11	Building Co - Professional Fees	(3,000)	19	11
12	Building Co - Closing Costs	(294,559)	21	12
13	Non-Allowable Legal	(36,776)	19	13
14	Non-Allowable Expense	(4,255)	43	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**	(535,218)		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 Oasis

IDF 0054833
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 Oasis # 0054833 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													1
2	Food Purchase	(40)											(40)	2
3	Housekeeping			2,546									2,546	3
4	Laundry													4
5	Heat and Other Utilities	(9,992)		1,643									(8,349)	5
6	Maintenance			1,864		(3,184)							(1,320)	6
7	Other (specify):*					2,180							2,180	7
8	**TOTAL General Services**	(10,032)		6,053		(1,004)							(4,983)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(110,769)							(110,769)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,421							5,421	15
16	**TOTAL Health Care and Programs**					(105,348)							(105,348)	16
	C. General Administration													
17	Administrative			(148,716)		29,452							(119,264)	17
18	Directors Fees													18
19	Professional Services	(53,934)	3,000	(390,774)	988	2,188							(438,532)	19
20	Fees, Subscriptions & Promotions	(14,347)	77	68		68							(14,134)	20
21	Clerical & General Office Expenses	(592,699)	294,558	107,867		52,509							(137,765)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			485		139							624	24
25	Other Admin. Staff Transportation					4,543							4,543	25
26	Insurance-Prop.Liab.Malpractice			1,048		2,525							3,573	26
27	Other (specify):*			25,280		12,884							38,164	27
28	**TOTAL General Administration**	(660,980)	297,635	(404,742)	988	104,308							(662,791)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(671,012)	297,635	(398,689)	988	(2,044)							(773,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Oasis # 0054833 **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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	388,554											388,554	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,105)	62,291	4	1,410		3,482						59,081	32
33	Real Estate Taxes		129,000		1,623		4,752						135,375	33
34	Rent-Facility & Grounds		(292,920)	18,545	(8,033)		(10,512)						(292,920)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(14,397)											(14,397)	36
37	TOTAL Ownership	366,052	(101,629)	18,548	(5,001)		(2,278)						275,692	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,378)				(14,400)							(19,778)	43
44	TOTAL Special Cost Centers	(5,378)				(14,400)							(19,778)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(310,339)	196,006	(380,140)	(4,013)	(16,444)	(2,278)						(517,208)	45

Facility Name & ID Number Prairie Oasis # 0054833 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. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 292,920	Prairie Oasis Realty LLC		$	$ (292,920)	1
2	V	20	Dues and Subscriptions		Prairie Oasis Realty LLC		77	77	2
3	V	32	Interest Expense		Prairie Oasis Realty LLC		62,291	62,291	3
4	V	19	Professional Fees		Prairie Oasis Realty LLC		3,000	3,000	4
5	V	33	Real Estate Taxes		Prairie Oasis Realty LLC		129,000	129,000	5
6	V	21	Closing Costs		Prairie Oasis Realty LLC		294,558	294,558	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 292,920			$ 488,926	$ * 196,006	14

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

Facility Name & ID Number Prairie Oasis # 0054833 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	Shimon Webster	44.07%	Center Home Hispanic Elderly	Chicago	Premier HC & Finacial	Skokie	Consulting Co	1
2	Yuruchom Levovitz	41.11%	Pine Crest Health Care	Hazel Crest	Premier HC Realty	Skokie	Building Co.	2
3	Jeffrey Webster	1.48%	Park View Rehab Center	Chicago	iCare Consulting Services	Skokie	Consulting Co	3
4	Eli Webster	0.74%	River View Rehab Center	Elgin	8131 Monticello Realty	Skokie	Building Co.	4
5	EZ&A LLC	0.74%	Forest City Nursing & Rehab	Rockford	Prairie Oasis Realty LLC	South Holland	Building Co.	5
6	Kevin Chankin	7.41%	Rock River Health Center	Rockford	iCare Health Services Incorporated	Burlington, VT	Insurance	6
7	CTCAAR LLC	1.48%	Pearl Pavillion	Freeport				7
8	Chaim Levovitz	1.48%	Oak Park Oasis	Oak Park				8
9	MIR Consultants Inc.	1.48%	Austin Oasis	Chicago				9
10								10
11								11
12								12
13								13
14								14
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 Oasis # 0054833 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 Oasis # 0054833 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	3	HOUSEKEEPING	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		$ 2,546	$ 2,546	15
16	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,643	1,643	16
17	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,864	1,864	17
18	V	17	ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		47,951	47,951	18
19	V	19	PROFESSIONAL FEES	393,333	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		2,559	(390,774)	19
20	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		68	68	20
21	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		6,041	6,041	21
22	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		101,826	101,826	22
23	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		485	485	23
24	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,048	1,048	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		25,280	25,280	25
26	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4	4	26
27	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		18,545	18,545	27
28	V	17	CONSULTING FEES	196,667	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(196,667)	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			$ 590,000			$ 209,860	$ * (380,140)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 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			$			$	$	15
16	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		988	988	16
17	V	20	LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30	DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32	INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		1,410	1,410	19
20	V	33	REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		1,623	1,623	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	8,033	PREMIER HEALTHCARE REALTY, LLC			(8,033)	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			$ 8,033			$ 4,020	$ * (4,013)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 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	6	REPAIRS AND MAINTENANCE	$ 21,600	ICARE CONSULTING SERVICES LLC		$ 18,416	$ (3,184)	15
16	V	7	R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		2,180	2,180	16
17	V	10	NURSING SALARIES	153,400	ICARE CONSULTING SERVICES LLC		42,631	(110,769)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		5,421	5,421	18
19	V	17	ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		29,452	29,452	19
20	V	19	PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		2,188	2,188	20
21	V	20	DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		68	68	21
22	V	21	CLERICAL AND GENERAL	29,400	ICARE CONSULTING SERVICES LLC		2,660	(26,740)	22
23	V	21	CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		79,249	79,249	23
24	V	24	SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		139	139	24
25	V	25	AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		4,543	4,543	25
26	V	26	INSURANCE		ICARE CONSULTING SERVICES LLC		2,525	2,525	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		12,884	12,884	27
28	V	43	MARKETING	14,400	ICARE CONSULTING SERVICES LLC			(14,400)	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			$ 218,800			$ 202,356	$ * (16,444)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 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			$			$	$	15
16	V	19	PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20	LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30	DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32	INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		3,482	3,482	19
20	V	33	REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		4,752	4,752	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	10,512	8131 MONTICELLO REALTY, LLC			(10,512)	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			$ 10,512			$ 8,234	$ * (2,278)	39

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

Facility Name & ID Number Prairie Oasis # 0054833 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	26	INSURANCE	$ 362,966	ICARE HEALTH SERVICES INCORPORATED CELL		$ 362,966	$	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			$ 362,966			$ 362,966	$ *	39

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

Facility Name & ID Number Prairie Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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	Shimon Webster	Member	Administrative	44.07%	See Attached	3.69	9.23%	Alloc Salary	$ 12,857	17-7	1
2	Yeruchom Levovitz	Member	Administrative	41.11%	See Attached	3.69	9.23%	Alloc Salary	12,012	17-7	2
3	Kevin Chankin	Member	Administrative	7.41%	See Attached	3.69	9.23%	Alloc Salary	23,083	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 47,952		13

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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 Oasis # 0054833 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: PREMIER HEALTHCARE & FIN. SVCS, INC.
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	$ 27,572	$	33,112	$ 2,546	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798		33,112	1,643	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184		33,112	1,864	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	33,112	47,951	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719		33,112	2,559	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738		33,112	68	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	33,112	6,041	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850		33,112	101,826	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249		33,112	485	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347		33,112	1,048	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803		33,112	25,280	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39		33,112	4	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851		33,112	18,545	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,272,926	$ 1,622,196		$ 209,860	25

Facility Name & ID Number Prairie Oasis # 0054833 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: PREMIER HEALTHCARE REALTY, LLC
Street Address: 8153 LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700		33,112	988	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			33,112		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			33,112		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267		33,112	1,410	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574		33,112	1,623	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					$ 43,541	$		$ 4,020	25

Facility Name & ID Number Prairie Oasis # 0054833 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: ICARE CONSULTING SERVICES LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 945-6107

	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	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	$ 145,610	$ 145,409	218,800	$ 18,416	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		218,800	2,180	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	218,800	42,631	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		218,800	5,421	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	218,800	29,452	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		218,800	2,188	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		218,800	68	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		218,800	2,660	8
9	21	CLERICAL & GENERAL WAGE	CONSULTING FEES	1,730,000	8	626,600	626,600	218,800	79,249	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		218,800	139	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		218,800	4,543	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		218,800	2,525	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		218,800	12,884	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,599,973	$ 1,341,950		$ 202,356	25

Facility Name & ID Number Prairie Oasis # 0054833 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: 8131 MONTICELLO REALTY, LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8			33,112		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			33,112		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			33,112		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708		33,112	3,482	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468		33,112	4,752	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					$ 89,176	$		$ 8,234	25

Facility Name & ID Number Prairie Oasis # 0054833 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: ICARE HEALTH SERVICES INCORP. CELL
Street Address: 30 MAIN STREET, SUITE 330
City / State / Zip Code: BURLINGTON, VERMONT 05401
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	26	INSURANCE	DIRECT ALLOCATION			$	$		$ 362,966	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					$	$		$ 362,966	25

Facility Name & ID Number Prairie Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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 Oasis # 0054833 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	CIBC Bank		X	Mortgage Payable			$	$ 10,206,720			$ 62,291	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank		X	Line of Credit							6,169	6
7	Allocated from Premier HC		X								4	7
8	See Supplemental Schedule										4,892	8
9	TOTAL Facility Related						$	$ 10,206,720			$ 73,356	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,105)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,105)	14
15	TOTALS (line 9+line14)						$	$ 10,206,720			$ 65,251	15

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

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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.**	$	405,759	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.)	$	513,720	2
3. Under or (over) accrual (line 2 minus line 1).	$	107,961	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	511,238	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.)**	$	17,250	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** $ 46,810 **For** 2018 **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.	$	636,448	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	453,550	8
	2016	471,597	9
	2017	481,336	10
	2018	495,557	11
	2019	507,345	12

Allocated From Premier HC Realty - $1,623

Allocated From 8131 Monticello Realty - $4,752

Beginning Accrual Adjusted - facility began accruing RE Taxes

	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 Oasis COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054833

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.	29-15-302-051-0000	Long Term Care Property	$ 507,345.28	$ 507,345.28
2.	10-23-324-047-0000	Allocated from Premier HC Realty	$ 34,381.62	$ 3,174.46
3.	10-23-325-045-0000	Allocated from 8131 Monticello	$ 51,467.63	$ 4,752.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 593,194.53	$ 515,271.76

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 Oasis COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054833

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 Oasis # 0054833 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [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		2020	$ 508,191	1
2	See attached allocations		see attached	6,209	2
3	TOTALS			$ 514,400	3

Facility Name & ID Number Prairie Oasis # 0054833 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	135		2020	1976	$ 8,045,490	$	35	$ 229,871	$ 229,871	$ 57,468	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		180,032			6,548	6,548	40,703	68
69	Financial Statement Depreciation			4,031			(4,031)		69
70	TOTAL (lines 4 thru 69)		$ 8,225,522	$ 4,031		$ 236,419	$ 232,388	$ 98,171	70

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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		$ 8,225,522	$ 4,031		$ 236,419	$ 232,388	$ 98,171	1
2	Replaced Mixing Valve	2019	3,131		20	157	157	314	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	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
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19									19
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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)		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	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
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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)		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	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
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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)		$ 8,228,653	$ 4,031		$ 236,576	$ 232,545	$ 98,485	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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
13									13
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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 Premiere Healthcare Realty, LLC	2011	34,384		20	982	982	8,923	3
4	Allocated Premiere Healthcare Realty, LLC	2012	4,378		20	125	125	1,126	4
5	Allocated from 8131 N. Monticello	2019	75,734		20	2,164	2,164	4,328	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier HC & Financial Services	2012	780		20	39	39	351	9
10	Allocated from Premier HC & Financial Services	2016	1,828		20	91	91	457	10
11									11
12	Allocated Premiere Healthcare Realty, LLC	2011	61,155		20	3,058	3,058	24,721	12
13	Allocated Premiere Healthcare Realty, LLC	2012	1,773		20	89	89	798	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 180,032	$		$ 6,548	$ 6,548	$ 40,703	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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		$ 180,032	$		$ 6,548	$ 6,548	$ 40,703	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
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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)		$ 180,032	$		$ 6,548	$ 6,548	$ 40,703	34

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 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	$ 1,559,801	$	$ 155,980	$ 155,980	10	$ 67,107	71
72	Current Year Purchases	284		28	28	10	28	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,560,085	$	$ 156,008	$ 156,008		$ 67,135	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,303,138	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 392,585	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 388,554	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 165,620	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 Oasis # 0054833 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: 16000 South Wabash LLC (1/1/20 - 9/30/20)

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:	1976	135	2/1/2018	$ 351,000			3
4	Additions							4
5	Allocated from Premier HC							5
6								6
7	TOTAL		135		$ 351,000 **			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: $ 9,498 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 Oasis # 0054833 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	$		$ 213,870	$		$ 213,870	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			108,813			108,813	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			189,134			189,134	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				65,831		65,831	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			34,808		5,108	6,702		46,618	13
14	TOTAL			$ 34,808		$ 516,925	$ 72,533		$ 624,266	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 Oasis **#** 0054833 **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	$ 2,424,150	$ 3,387,103	1
2	Cash-Patient Deposits	9,863	9,863	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,000,394	1,000,394	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	496,736	496,736	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	17,753	17,753	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,948,896	$ 4,911,849	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		508,191	13
14	Buildings, at Historical Cost		8,045,490	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	21,718	1,527,037	16
17	Accumulated Depreciation (book methods)	(10,636)	(10,636)	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	3,017	3,017	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,099	$ 10,073,099	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,962,995	$ 14,984,948	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 311,278	$ 311,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,000	2,000	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,757	192,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	147,047	147,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)		511,238	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,005,900	1,005,900	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,658,982	$ 2,170,221	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,206,720	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	290,250	290,250	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 290,250	$ 10,496,970	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,949,232	$ 12,667,191	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,013,763	$ 2,317,757	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,962,995	$ 14,984,948	48

***(See instructions.)**

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 606,162	1
2	Restatements (describe):		2
3	Equity Restatement	145	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 606,307	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,407,456	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,407,456	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)**	$ 2,013,763	24 *

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 8,274,624	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,274,624	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,970	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 320,970	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,105	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,105	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,120,988	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,120,988	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,724,687	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,166,993	31
32	Health Care	2,735,959	32
33	General Administration	2,338,955	33
	B. Capital Expense		
34	Ownership	1,161,839	34
	C. Ancillary Expense		
35	Special Cost Centers	644,044	35
36	Provider Participation Fee	269,441	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,317,231	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,407,456	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,407,456	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,560,506	44
45	Private Pay - Net Inpatient Revenue	168,454	45
46	Medicare - Net Inpatient Revenue	2,230,465	46
47	Other-(specify) Hospice	233,815	47
48	Other-(specify) Insurance	81,384	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,274,624	49

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

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

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

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

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,721	1,850	$ 90,758	$ 49.06	1
2	Assistant Director of Nursing	1,503	1,615	67,108	41.55	2
3	Registered Nurses	10,286	11,465	358,211	31.24	3
4	Licensed Practical Nurses	24,176	25,981	690,291	26.57	4
5	CNAs & Orderlies	55,434	59,573	810,446	13.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,772	2,979	68,418	22.97	8
9	Activity Director	1,998	2,147	41,057	19.12	9
10	Activity Assistants	5,189	5,577	69,486	12.46	10
11	Social Service Workers	4,527	4,865	116,010	23.85	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,081	40,998	19.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,426	17,653	227,164	12.87	15
16	Dishwashers					16
17	Maintenance Workers	3,797	4,081	80,351	19.69	17
18	Housekeepers	15,742	16,917	216,510	12.80	18
19	Laundry	6,551	7,040	85,136	12.09	19
20	Administrator	2,456	2,640	106,791	40.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,121	6,578	86,470	13.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,844	1,981	34,244	17.29	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,611	2,806	34,808	12.40	33
34	TOTAL (lines 1 - 33)	165,090	177,829	$ 3,224,257 *	$ 18.13	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	216	$ 10,442	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	155,400	10-03	38
39	Pharmacist Consultant	Monthly	9,515	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,206	11-03	44
45	Social Service Consultant	45	2,757	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	$ 201,720		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Amico	Administrator	0	$ 85,561
Dilane Lofton	Administrator	0	21,230
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,791

B. Administrative - Other

Description	Amount
Consulting Fees Premier HC & Financial Sercives	$ 196,667
TOTAL (agree to Schedule V, line 17, col. 3)	$ 196,667
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 39,642
Premier HC & Financial Services	Bookkeeping Fees	393,333
Prospect Resources	Energy Procurement	1,300
Point Click Care	Data Processing	23,898
Reliable Health Care	Data Processing	11,800
Creative Technologies	IT Support	18,939
Ability Network	Medicare Billing	1,917
Zirmed	Data Processing	640
OnShift	HR Consulting	11,973
EON Applications	Computer Services	978
See Attached	Legal	36,919
See Supplemental Schedule		16,502
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 557,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,161
Unemployment Compensation Insurance	43,084
FICA Taxes	246,656
Employee Health Insurance	137,572
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	28,802
Other Employee Expense	27,109
Holiday Expense	2,764
TOTAL (agree to Schedule V, line 22, col.8)	$ 541,148

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,213
Health Care Worker Background Check	
(Indicate # of checks performed 231)	2,307
Patient Background Checks	
Dues & Subscriptions	12,816
Licenses & Fees	4,822
See Supplemental Schedule	136
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,294

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,547
See Supplemental Schedule	624
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,171

**See instructions.

Facility Name & ID Number Prairie Oasis # 0054833 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI: $25,631**

(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. $ **18,135** 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. $ **269,441**
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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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