		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 South Chestnut Street (Number) Pana (City) 62557 (Zip Code)

County: Christian

Telephone Number: (217) 562-3996 **Fax #** (217) 562-4005

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2000

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	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	105	TOTALS	105	38,325	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	15,195	1,099	1,445	17,739	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,195	1,099	1,445	17,739	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.29%

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

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

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

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

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 3/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 1,378

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	135,475	20,186	2,901	158,562		158,562	(2,172)	156,390			1
2	Food Purchase		135,434		135,434		135,434		135,434			2
3	Housekeeping	90,995	17,980		108,975		108,975		108,975			3
4	Laundry	25,440	10,123		35,563		35,563		35,563			4
5	Heat and Other Utilities			99,416	99,416		99,416		99,416			5
6	Maintenance	38,093	4,493	17,577	60,163		60,163		60,163			6
7	Other (specify):*											7
8	TOTAL General Services	290,003	188,216	119,894	598,113		598,113	(2,172)	595,941			8
	B. Health Care and Programs											
9	Medical Director			14,250	14,250		14,250		14,250			9
10	Nursing and Medical Records	807,935	87,790	658,614	1,554,339		1,554,339	(2,606)	1,551,733			10
10a	Therapy			326,076	326,076		326,076		326,076			10a
11	Activities	38,047	41		38,088		38,088	(553)	37,535			11
12	Social Services	44,945			44,945		44,945		44,945			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	890,927	87,831	998,940	1,977,698		1,977,698	(3,159)	1,974,539			16
	C. General Administration											
17	Administrative	69,996		214,000	283,996		283,996		283,996			17
18	Directors Fees											18
19	Professional Services			65,633	65,633		65,633	(46,891)	18,742			19
20	Dues, Fees, Subscriptions & Promotions			1,121	1,121		1,121		1,121			20
21	Clerical & General Office Expenses	46,378	1,459	21,959	69,796		69,796	(101)	69,695			21
22	Employee Benefits & Payroll Taxes			142,447	142,447		142,447		142,447			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,120	3,120		3,120		3,120			25
26	Insurance-Prop.Liab.Malpractice			75,694	75,694		75,694		75,694			26
27	Other (specify):*											27
28	TOTAL General Administration	116,374	1,459	523,974	641,807		641,807	(46,992)	594,815			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,297,304	277,506	1,642,808	3,217,618		3,217,618	(52,323)	3,165,295			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 Rose Health Care Center #0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			87,729	87,729		87,729	(17,039)	70,690			30
31	Amortization of Pre-Op. & Org.			12,568	12,568		12,568		12,568			31
32	Interest			157,043	157,043		157,043	(77)	156,966			32
33	Real Estate Taxes			61	61		61	(61)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,884	15,884		15,884		15,884			35
36	Other (specify):*											36
37	**TOTAL Ownership**			273,285	273,285		273,285	(17,177)	256,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,677		23,677		23,677		23,677			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,602	155,602		155,602		155,602			42
43	Other (specify):*	26,774	156	143,721	170,651		170,651	(170,651)				43
44	**TOTAL Special Cost Centers**	26,774	23,833	299,323	349,930		349,930	(170,651)	179,279			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,324,078	301,339	2,215,416	3,840,833		3,840,833	(240,151)	3,600,682			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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,172)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,395)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,039)	30		9
10	Interest and Other Investment Income	(77)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(131,064)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(46,891)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,391)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,122)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (240,151)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (240,151)		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 Rose Health Care Center

ID# 0045245

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,147)	43	1
2	X-Rays-Part A	(2,759)	43	2
3	Pet Expense	(898)	43	3
4	Disallowed Special Events	3	43	4
5	Transportation Revenue Offset	(553)	11	5
6	Offset Nursing Miscellaneous Income	(2,606)	10	6
7	Offset Office Supplies Miscellaneous Income	(101)	21	7
8	Disallowed R.E. Taxes	(61)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,122)		49

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SJL Health Systems, Inc.	100					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 6A-Board of Directors

President
Mr. Michael Kuhl
Kuhl and Company
632 West Jefferson
Morton, Illinois 61550

Secretary
Thomas Hammerton
3400 W. Brenwick Drive
Peoria, IL 61614

Treasurer
Becky Stokes
830 W. Trailcreek Drive
Peoria, IL 61614

Director at Large
Dr. Michael A. Ahearn
Ahearn and Associates Medical Center
Arrow Towers North
513 Elliott Street
Kewanee, IL 61443

None of the Board members directly provided services to the nursing home

Michael Kuhl has ownership in Kuhl & Company and has provided services as insurance agent for the nursing home

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] 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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Wells Fargo		X	Mortgage	$21,167.65	12/01/02	$ 3,580,869	$ 2,496,435	11/1/35	0.0618	$ 157,043	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,167.65		$ 3,580,869	$ 2,496,435			$ 157,043	9
	B. Non-Facility Related*											
10								Interest Income Offset			(77)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (77)	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 2,496,435			$ 156,966	15

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 61	2
3. Under or (over) accrual (line 2 minus line 1).		$ 61	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Disallowed R.E. Taxes**	(61)	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	37	8
	2016	42	9
	2017	48	10
	2018	54	11
	2019	61	12

Accrual based on prior year tax bill.

	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 Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-25-21-401-010-00	Land	$ 61.32	$ 61.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61.32	$ 61.32

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 443,042 2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 12,568 4. Dates Incurred: 2013

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	28,000	1995	$ 13,500	1
2					2
3	TOTALS	28,000		$ 13,500	3

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1995	1976	$ 1,068,665	$	30	$ 35,622	$ 35,622	$ 920,236	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986-1998 Additions				1,643,090					1,643,090	9
10	Sidewalk & Pad			1999	1,484		15			1,484	10
11	Divide Receipts on Emergency Generator			1999	2,397		20	58	58	2,397	11
12	Med Room Cabinets and Counter Top			1999	2,008		20	104	104	2,008	12
13	Door Alarms			2001	1,215		15			1,215	13
14	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	58,425	14
15	Wooded Doors			2001	1,900		15			1,900	15
16	Landscaping-Renovation Project			2001	1,174		10			1,174	16
17	Bituminous Parking Lot			2001	22,030		8			22,030	17
18	Replace Plumbing Fixtures			2002	$ 2,490	$	20	$ 125	125	2,247	18
19	Therapy Room Remodel			2002	5,617		20	281	281	4,917	19
20	Remodel Medication/Utility Rooms			2002	7,909		20	395	395	6,915	20
21	Breakroom Remodel			2002	3,106		10			3,106	21
22	Exterior Window Covering			2002	7,650		7			7,650	22
23	Lights for Therapy Room			2002	805		10			805	23
24	Renovation on Facility Floors and Walls			2002	36,842		20	1,842	1,842	31,468	24
25	Fire Supression System			2004	1,540		10			1,540	25
26	Antenna			2004	2,944		10			2,944	26
27	Sign			2004	1,200		10			1,200	27
28	Carpet			2005	1,281		5			1,281	28
29	Sidewalks			2006	8,735		10			8,735	29
30	Duct Work			2007	5,120		15	342	342	4,275	30
31	Sidewalks			2007	8,976		15	598	598	7,475	31
32	Water Heater & Duct Work			2008	4,850		10			4,850	32
33	Air Conditioner-Rooftop			2008	9,120		10	912	912	7,398	33
34	Plumbing Repair			2008	3,442		10			3,442	34
35	Ceramic Tile Replacement			2008	9,996		20	500	500	5,750	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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Vinyl Tile Replacement	2008	4,495		20	225	$ 225	$ 2,700	37
38	Sidwalk Marquee	2008	4,985		10			4,985	38
39	Generator Repair	2008	2,562		10			2,562	39
40	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	8,326	40
41	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	7,567	41
42	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	14,582	42
43	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	6,210	43
44	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	11,983	44
45	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	17,181	45
46	Tiling for Bathroom	2009	13,519		15	902	902	9,471	46
47	Generator Repair	2009	3,984		7			3,984	47
48	Air Conditioner-Rooftop	2009	10,281		15	686	686	2,203	48
49	Wandering Patient Alarm System	2010	5,050		7			5,050	49
50	Sprinkler System Repair	2009	33,658		10			25,245	50
51	Water Heater	2011	3,356		7			3,356	51
52	Fire Alarm Control Installation	2012	2,958		7	215	215	2,958	52
53	Landscaping	2013	10,158		15	678	678	4,407	53
54	Parking Lot Repair	2013	2,500		7	358	358	2,327	54
55	Water Pipe Repair	2014	7,170		7	1,024	1,024	5,632	55
56	Gutters and Soft	2014	7,936		25	317	317	1,744	56
57	Patio Replacement	2014	9,592		15	640	640	3,520	57
58	Roof Replacement	2015	222,650		25	8,906	8,906	40,077	58
59	Cooler Refrigeration Repair	2019	7,373		7	527	527	527	59
60	Roof Top Air Conditioner	2020	10,138		15	338	338	338	60
61									61
62									62
63	Land and Improvements			1,276			(1,276)		63
64	Building Booked			63,342			(63,342)		64
65	Building Improvement Booked			21,138			(21,138)		65
66									66
67	2020-Home Office Allocation-Building Improvements								67
68	2020-Home Office Allocation-Land Improvements								68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,436,769	$ 85,756		$ 64,465	$ (21,291)	$ 2,946,892	70

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 87,248	$ 1,973	$ 6,225	$ 4,252	5-10 yrs.	$ 78,643	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,119,864					1,119,864	73
74	Home Office Allocation							74
75	TOTALS	$ 1,207,112	$ 1,973	$ 6,225	$ 4,252		$ 1,198,507	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)	$ 4,657,381	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,729	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,690	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,039)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,145,399	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,884 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	6,933
Dishwasher		660
Copier		8,291
		15,884

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	10A(3)	hrs	$	8,360	$ 125,399	$	8,360	$ 125,399	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,172	92,587		6,172	92,587	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,266	108,090		7,266	108,090	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				23,677		23,677	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	21,798	$ 326,076	$ 23,677	21,798	$ 349,753	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.

STATE OF ILLINOIS

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (177,726)	$ (177,726)	1
2	Cash-Patient Deposits	28,555	28,555	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 304,815)	1,563,173	1,563,173	3
4	Supply Inventory (priced at Cost)	13,727	13,727	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,101	29,101	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,456,830	$ 1,456,830	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	67,073	13,500	13
14	Buildings, at Historical Cost	2,842,209	1,068,665	14
15	Leasehold Improvements, at Historical Cost	527,444	2,368,104	15
16	Equipment, at Historical Cost	1,207,112	1,207,112	16
17	Accumulated Depreciation (book methods)	(4,064,200)	(4,145,399)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	473,042	473,042	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(253,303)	(253,303)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrows and Reserves	449,848	449,848	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,249,225	$ 1,181,569	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,706,055	$ 2,638,399	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,022,723	$ 1,022,723	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,555	28,555	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,247	107,247	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,221	63,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,857	12,857	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,636	5,636	35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,090	1,090	36
37	Accrued Management Fees	744,476	744,476	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,985,805	$ 1,985,805	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,496,435	2,496,435	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	947,605	947,605	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,444,040	$ 3,444,040	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,429,845	$ 5,429,845	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,723,790)	$ (2,791,446)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,706,055	$ 2,638,399	48

*(See instructions.)

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,519,377)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,519,376)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,414)	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)**	$ (204,414)	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)**	$ (2,723,790)	24 *

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,535,971	1
2	Discounts and Allowances for all Levels	(500,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,034,991	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	492,437	6
7	Oxygen	929	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 493,366	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,172	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,750	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,539	20
21	Other Medical Services	4,225	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50,686	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	77	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	553	28
28a	Miscellaneous and Stimulus Revenue	56,746	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 57,299	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,636,419	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	598,113	31
32	Health Care	1,977,698	32
33	General Administration	641,807	33
	B. Capital Expense		
34	Ownership	273,285	34
	C. Ancillary Expense		
35	Special Cost Centers	194,328	35
36	Provider Participation Fee	155,602	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,840,833	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,414)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (204,414)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,336,658	44
45	Private Pay - Net Inpatient Revenue	207,950	45
46	Medicare - Net Inpatient Revenue	481,241	46
47	Other-(specify) Insurance Net Inpatient Revenue	9,142	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,034,991	49

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

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,374	2,483	$ 65,782	$ 26.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,271	1,290	38,513	29.86	3
4	Licensed Practical Nurses	9,602	9,731	246,861	25.37	4
5	CNAs & Orderlies	25,653	26,673	364,687	13.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,313	1,337	25,141	18.80	9
10	Activity Assistants	480	480	5,633	11.74	10
11	Social Service Workers	2,006	2,109	44,945	21.31	11
12	Dietician					12
13	Food Service Supervisor	2,075	2,109	28,042	13.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,861	11,156	107,433	9.63	15
16	Dishwashers					16
17	Maintenance Workers	1,837	1,988	38,093	19.16	17
18	Housekeepers	8,150	8,654	90,995	10.51	18
19	Laundry	2,080	2,080	25,440	12.23	19
20	Administrator	1,956	1,956	69,996	35.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,682	2,739	46,378	16.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,919	5,049	126,139	24.98	33
34	TOTAL (lines 1 - 33)	77,259	79,834	$ 1,324,078 *	$ 16.59	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	50	$ 2,901	L1, C3	35
36	Medical Director	Monthly	14,250	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,578	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	$ 22,729		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,533	$ 161,707	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	29,008	491,329	L10,C3	52
53	TOTAL (lines 50 - 52)	33,541	$ 653,036		53

Prairie Rose Health Care Center
0045245
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,582	1,629	50,176	30.80
Alzheimer's Coordinator	387	387	13,695	35.39
Resident Care Coordinator	1,207	1,290	28,221	21.88
Transportation	560	560	7,273	12.99
Marketing	1,183	1,183	26,774	22.63
TOTAL	4,919	5,049	126,139	

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashlie Schmitz	Administrator	0	$ 48,996
John Shaw	Administrator	0	21,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,996

B. Administrative - Other

Description	Amount
Management Fees	$ 214,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 214,000

C. Professional Services

Vendor/Payee	Type	Amount
Consolidated Communications	Computer Services	$ 6,365
Allscripts	Computer Services	2,273
Ability Network	Computer Services	1,176
Ginoli and Company	Accounting Fees	8,765
Illinois Secretary of State	Legal Fees	163
Susan Phillips and Roseblhum	Legal Settlement	46,891
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 65,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,847
Unemployment Compensation Insurance	1,115
FICA Taxes	94,211
Employee Health Insurance	5,011
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	(13)
Life Insurance	(694)
Employee Retirement	966
Administrator Benefits	14,004
TOTAL (agree to Schedule V, line 22, col.8)	$ 142,447

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	(84)
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 14	410
Miscellaneous Licenses & Permits	795
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,121

G. Schedule of Travel and Seminar**

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

**See instructions.

#REF!
#REF!
Period Beginning **#REF!**
Period End **#REF!**

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	787
Auto Repairs		2,057
Mileage-Travel		276
		3,120

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,480** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **155,602**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,172**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **553**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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