		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: 0018044

Facility Name: Prairieview Lutheran Home

Address: PO Box 4 (Number) Danforth (City) 60930 (Zip Code)

County: Iroquois

Telephone Number: 815-269-2970 **Fax #** 815-269-2930

HFS ID Number:

Date of Initial License for Current Owners: 2/14/74

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Thomas McCann **Telephone Number:** 815-269-2970
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 1/1/20 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) Thomas McCann
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Marcie Meents Kolberg, CPA
(Firm Name & Address) SKDO, PC, 1605 N Convent, Bourbonnais, IL 60914
(Telephone) 815-937-1997 Fax # 815-935-0360

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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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 90

	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	90	Skilled (SNF)	90	32,940	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	90	TOTALS	90	32,940	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	4,446	21,698	885	27,029	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,446	21,698	885	27,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.06%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
out-patient therapy

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 02/14/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 90 and days of care provided 885

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [s] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	506,240	41,482	9,958	557,680		557,680		557,680			1
2	Food Purchase		305,638		305,638	(9,991)	295,647	(880)	294,767			2
3	Housekeeping	169,231	51,421		220,652		220,652		220,652			3
4	Laundry	86,081	19,574		105,655		105,655		105,655			4
5	Heat and Other Utilities			137,382	137,382		137,382	(23,176)	114,206			5
6	Maintenance	137,789	4,642	80,058	222,489		222,489		222,489			6
7	Other (specify):* medical waste			17,898	17,898		17,898		17,898			7
8	TOTAL General Services	899,341	422,757	245,296	1,567,394	(9,991)	1,557,403	(24,056)	1,533,347			8
	B. Health Care and Programs											
9	Medical Director					4,800	4,800		4,800			9
10	Nursing and Medical Records	2,709,750	258,057	56,821	3,024,628	(42,808)	2,981,820		2,981,820			10
10a	Therapy			362,937	362,937		362,937	(41,933)	321,004			10a
11	Activities	191,790	5,982	2,637	200,409		200,409		200,409			11
12	Social Services	45,831		1,240	47,071		47,071		47,071			12
13	CNA Training		1,306		1,306		1,306		1,306			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,947,371	265,345	423,635	3,636,351	(38,008)	3,598,343	(41,933)	3,556,410			16
	C. General Administration											
17	Administrative	100,443			100,443		100,443		100,443			17
18	Directors Fees											18
19	Professional Services			83,157	83,157		83,157		83,157			19
20	Dues, Fees, Subscriptions & Promotions			27,649	27,649		27,649	(19,460)	8,189			20
21	Clerical & General Office Expenses	313,284	14,513	299,391	627,188	(4,800)	622,388	(64,970)	557,418			21
22	Employee Benefits & Payroll Taxes			1,064,923	1,064,923	9,991	1,074,914		1,074,914			22
23	Inservice Training & Education			1,033	1,033		1,033		1,033			23
24	Travel and Seminar			2,110	2,110		2,110		2,110			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,529	62,529		62,529		62,529			26
27	Other (specify):*											27
28	TOTAL General Administration	413,727	14,513	1,540,792	1,969,032	5,191	1,974,223	(84,430)	1,889,793			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,260,439	702,615	2,209,723	7,172,777	(42,808)	7,129,969	(150,419)	6,979,550			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 Prairieview Lutheran Home #0018044 Report Period Beginning: 1/1/20 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			223,679	223,679		223,679		223,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			2,953	2,953		2,953		2,953			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			226,632	226,632		226,632		226,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8,698	8,698		8,698		8,698			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,979	217,979		217,979		217,979			42
43	Other (specify):* see page 5					42,808	42,808		42,808			43
44	**TOTAL Special Cost Centers**			226,677	226,677	42,808	269,485		269,485			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,260,439	702,615	2,663,032	7,626,086		7,626,086	(150,419)	7,475,667			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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	(41,933)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(880)	2		4
5	Telephone, TV & Radio in Resident Rooms	(23,176)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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				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	(64,970)	21		24
25	Fund Raising, Advertising and Promotional	(19,460)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,419)		$	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))**	$ (150,419)		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			3,558		42
43	Prescription Drugs			39,250		43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 42,808		47

Prairieview Lutheran Home

ID# 0018044

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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

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.

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	Sam Sweeney	BOD						1
2	Cyndy Clapp	BOD						2
3	Fred Hurliman	BOD						3
4	Diane Goldenstein	BOD						4
5	Doug Benner	BOD						5
6	Myra Manssen	BOD						6
7	Jerry Henrichs	BOD						7
8	Kris Ritzma	BOD						8
9	Pastor Don Gillespie	BOD						9
10								10
11								11
12	Note: none of the BOD receive any compensation							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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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			x	purchase of copiers	$1,045.00	9/20/18	$ 29,703	$ 19,157	12/20/23	NA	$ 3,410	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,045.00		$ 29,703	$ 19,157			$ 3,410	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 29,703	$ 19,157			$ 3,410	15

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

*** 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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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.**	$	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.)		$ 2,953	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,953	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. **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.		$ 2,953	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	2,787	8
2016	2,790	9
2017	2,742	10
2018	2,738	11
2019	2,953	12

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 Prairieview Lutheran Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0018044

CONTACT PERSON REGARDING THIS REPORT Thomas McCann

TELEPHONE 815-269-2970 FAX #: 815-269-2930

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.	17-18-201-006	PT W2 NE 2.08 acres	$ 418.26	$ 418.26
2.	17-18-202-001/17-18-202-002	Prairieview 3rd add lt 6 and 5	$ 122.32	$ 122.32
3.	17-18-202-003/17-18-202-004	Prairieview 3rd add lt 4 and 3	$ 122.32	$ 122.32
4.	17-18-202-005/17-18-202-006	Prairieview 4th add lt 6 and 7	$ 122.32	$ 122.32
5.	17-18-226-002	Prairieview add lt 1	$ 15.00	$ 15.00
6.	17-18-226-006	Prairieview 4th add lt 5	$ 398.38	$ 398.38
7.	17-18-226-007	Prairieview 4th add lt 4	$ 395.76	$ 395.76
8.	17-18-226-008	Prairieview 4th add lt 3	$ 395.76	$ 395.76
9.	17-18-226-009	Prairieview 4th add lt 2	$ 395.76	$ 395.76
10.	17-18-226-010	Prairieview 4th add lt 1	$ 395.76	$ 395.76
		TOTALS	$ 2,781.64	$ 2,781.64

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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,200 B. General Construction Type: Exterior brick Frame steel and brick 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. [ ] (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).

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	building/grounds	304,920	1971	$ 9,115	1
2					2
3	TOTALS	304,920		$ 9,115	3

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	60			1973	$ 649,567	$	40	$	$	$ 649,567	4
5				1995	1,013,622	20,193	40	20,193		637,421	5
6	30			1996	1,834,874	45,866	40	45,866		1,085,628	6
7											7
8											8
	Improvement Type**										
9	Fully depreciated				823,225					823,225	9
10	Prior to 2009				421,771	3,637		3,637		213,997	10
11				2009	199,130	5,992	various	5,992		59,740	11
12				2010	254,622	6,363	various	6,363		66,316	12
13				2013	112,654	3,423	various	3,423		26,201	13
14				2014	2,975	298	various	298		2,043	14
15				2014	29,188	1,460	10	1,460		9,056	15
16	Patient rooms flooring (325-341, 422-429)			2015	31,378	3,138	20	3,138		17,782	16
17	Remodel nurses' station			2015	6,309	252	10	252		1,407	17
18							25				18
19	New room heaters (6)			2015	9,868	987		987		5,264	19
20	Gas water heater			2015	7,828	783	10	783		4,633	20
21	Boiler replacement			2015	107,645	4,305	10	4,305		24,396	21
22	Sidewalk replacement			2015	10,861	1,086	25	1,086		6,064	22
23							10				23
24											24
25	Patient rooms telephone upgrades (325-341, 422-429)			2015	15,501	620	25	620		3,307	25
26	Patient rooms wallcoverings (325-341, 422-429)			2015	52,114	2,085	25	2,085		11,120	26
27	Patient rooms electrical upgrades (325-341, 422-429			2015	4,375	175	25	175		933	27
28	Patient rooms new cabinetry (325-341, 422-429)			2015	289,695	11,588	25	11,588		61,803	28
29	Patient rooms plumbing (325-341, 422-429)			2015	69,462	2,778	25	2,778		14,816	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	Gas room furnace	2016	$ 6,392	$ 639	10	$ 639	$	$ 2,663	37
38	Patient rooms carpeting (235-251, 324, 112, 146, 414-417)	2016	11,748	1,175	10	1,175		5,572	38
39	Patient rooms cabinetry (235-251, 324, 112, 146, 414-417)	2016	171,857	6,874	25	6,874		32,726	39
40	Patient rooms plumbing (235-251, 324, 112, 146, 414-417)	2016	17,988	1,799	10	1,799		8,402	40
41	Window cubicle panels (63 rooms)	2016	19,750	1,975	10	1,975		9,052	41
42	Carpeting/flooring-nurses' station	2016	4,072	407	10	407		1,866	42
43	Hallway carpet and basecove	2016	47,287	4,729	10	4,729		20,952	43
44	Nurses' station plumbing	2016	1,650	165	10	165		729	44
45	Heat exchanger	2016	4,085	408	10	408		1,972	45
46	Carrier RTU roof top unit	2017	15,699	784	20	784		2,744	46
47	Aluminum cooler floor-kitchen	2017	2,990	299	10	299		997	47
48	Rooftop HVAC unit above conference room	2017	8,905	890	10	890		2,893	48
49	Heat exchanger-south roof top	2017	4,957	496	10	496		1,571	49
50	Kohler generator	2017	2,353	253	10	253		779	50
51	Heating units for patient rooms-Faith Place	2017	4,129	413	10	413		1,617	51
52	Locking system-Faith Place	2017	4,819	482	10	482		1,486	52
53	Metal roof rear porch-Faith Place	2017	5,461	137	40	137		468	53
54	Sealcoating repair-main lot	2017	15,244	762	20	762		2,604	54
55	Garden improvements	2018	2,670	133	20	133		366	55
56	Exterior sign 48" x 70"	2018	980	49	20	49		143	56
57	Delay egress magnet project	2018	2,768	276	10	276		760	57
58									58
59									59
60									60
61	12.5 ton carrier unit	2019	15,000	1,500	10	1,500		1,875	61
62	South roof	2019	88,660	2,216	40	2,216		3,509	62
63	Sewer line	2019	5,894	147	10	147		196	63
64	Dining room carpentry	2020	68,271	893	25	893		893	64
65	Dining room vinyl flooring	2020	21,762	272	20	272		272	65
66	Hollow core metal doors-entrance	2020	16,893	516	30	516		516	66
67	Dining room electrical	2020	12,116						67
68	Dining room plumbing		8,901						68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,539,965	$ 143,718		$ 143,718	$	$ 3,832,342	70

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	$ 699,037	$ 68,989	$ 68,989	$	various	$ 395,496	71
72	Current Year Purchases	41,748	3,797	3,797		various	3,797	72
73	Fully Depreciated Assets	1,017,205					1,017,205	73
74								74
75	TOTALS	$ 1,757,990	$ 72,786	$ 72,786	$		$ 1,416,498	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	2010 Ford Elkhart	2010	$ 45,949	$ 1,914	$ 1,914	$	10	$ 45,949	76
77	Resident transportation	2007 Ford Conversion Van	2010	36,393	3,035	3,035		10	36,393	77
78	Resident transportation	Major repair-van	2013	2,261	226	226		10	1,789	78
79	Resident transportation	2007 Chrysler Town/Ctry	2017	20,000	2,000	2,000		10	6,857	79
80	TOTALS			$ 104,603	$ 7,175	$ 7,175	$		$ 90,988	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)	$ 8,411,673	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 223,679	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 223,679	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,339,828	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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: $ Description:
(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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	2,272	$ 134,714	$	2,272	$ 134,714	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,128	65,361		1,128	65,361	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		2,835	215,185		2,835	215,185	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	6,235	$ 415,260	$	6,235	$ 415,260	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	$ 1,104,793	$	1
2	Cash-Patient Deposits	10,726		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	352,726		3
4	Supply Inventory (priced at cost)	65,067		4
5	Short-Term Investments			5
6	Prepaid Insurance	52,247		6
7	Other Prepaid Expenses	6,184		7
8	Accounts Receivable (owners or related parties)	174,587		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,766,330	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,115		13
14	Buildings, at Historical Cost	6,237,471		14
15	Leasehold Improvements, at Historical Cost	302,494		15
16	Equipment, at Historical Cost	1,862,593		16
17	Accumulated Depreciation (book methods)	(5,339,828)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,071,845	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,838,175	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 153,694	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,200		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,888		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	profit sharing payable	24,014		36
37	payroll withholding	610		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 466,406	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,157		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PPP loan payable	1,160,262		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,179,419	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,645,825	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,192,350	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,838,175	$	48

*(See instructions.)

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,387,286	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,387,286	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(194,936)	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)**	$ (194,936)	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)**	$ 3,192,350	24 *

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	$ 6,863,310	1
2	Discounts and Allowances for all Levels	(632,220)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,231,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	56,715	5
6	Therapy	437,986	6
7	Oxygen	15,332	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 510,033	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	538,488	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,871	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)**	$ 549,359	23
	D. Non-Operating Revenue		
24	Contributions	93,162	24
25	Interest and Other Investment Income***	1,072	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 94,234	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Reimbursements and other	46,434	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,431,150	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,567,394	31
32	Health Care	3,638,751	32
33	General Administration	1,966,632	33
	B. Capital Expense		
34	Ownership	226,632	34
	C. Ancillary Expense		
35	Special Cost Centers	8,698	35
36	Provider Participation Fee	217,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,626,086	40
41	**Income before Income Taxes (line 30 minus line 40)****	(194,936)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (194,936)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 662,369	44
45	Private Pay - Net Inpatient Revenue	5,054,685	45
46	Medicare - Net Inpatient Revenue	514,036	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,231,090	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 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	2,064	2,160	$ 95,448	$ 44.19	1
2	Assistant Director of Nursing	5,976	6,477	193,948	29.94	2
3	Registered Nurses	20,615	22,126	612,850	27.70	3
4	Licensed Practical Nurses	24,407	25,859	612,204	23.67	4
5	CNAs & Orderlies	93,465	98,976	1,164,875	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,746	1,944	33,249	17.10	9
10	Activity Assistants	13,385	14,171	158,541	11.19	10
11	Social Service Workers	2,040	2,160	46,216	21.40	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,160	52,911	24.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,033	34,099	453,329	13.29	15
16	Dishwashers					16
17	Maintenance Workers	5,023	5,506	137,789	25.03	17
18	Housekeepers	12,839	13,675	169,231	12.38	18
19	Laundry	8,024	8,353	86,081	10.31	19
20	Administrator	1,606	1,728	100,443	58.13	20
21	Assistant Administrator					21
22	Other Administrative	10,243	11,040	262,828	23.81	22
23	Office Manager					23
24	Clerical	4,259	4,379	50,457	11.52	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	732	732	11,016	15.05	31
32	Other Health Care(specify)	1,660	1,716	19,408	11.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,117	257,261	$ 4,260,824 *	$ 16.56	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	154	$ 8,207	1,3	35
36	Medical Director	72	4,800		36
37	Medical Records Consultant			10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	127	2,122	10,3	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	52	1,240	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	405	$ 16,369		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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas McCann	administrator	0	$ 100,443
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,443

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Borschnack Pelletier	auditor	$ 11,700
SKDO PC	CPA outside acct	34,780
Benefit Planning Consultants	HRA administration	1,900
Marcum Accountants	Medicare cost report	4,635
Capital Group Retirement Serv	administrator-Am Funds	375
Clifton Larson Allen	401K auditor	9,100
Duane Morris	attorney	19,917
Dyatech LLC	pension admin	750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 83,157

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,426
Unemployment Compensation Insurance	9,737
FICA Taxes	297,986
Employee Health Insurance	561,434
Employee Meals	9,991
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Life Insurance	7,571
401K	24,389
Health savings account contributions	30,380
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,074,914

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,400
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 21)	830
Patient Background Checks 23	230
Dues and fees	3,682
Subscriptions	1,047
Other promations	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,189

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,291
Seminar Expense	819
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,110

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/20 Ending: 12/31/20

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?

(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?

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,875** Line **10,2**

(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.

(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. $ **217,979**
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. $ **9,991** Has any meal income been offset against related costs? **no** 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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? **na**
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. $ **na**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Borschnack Pelletier and Co**

(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.