

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0042671</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Prairie Village Hlthcare Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> 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.	
Address: <u>1024 West Walnut</u> <u>Jacksonville</u> <u>62650</u>			
Number City Zip Code			
County: <u>Morgan</u>			
Telephone Number: <u>(217) 245-5175</u> Fax # <u>(217) 243- 4276</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>5/1/1997</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Joshua S. Banach</u>		Telephone Number: <u>(847) 628 - 8784</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Denise A Leonard, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>1111 Superior Ave, Suite 1250 Cleveland, OH 44114</u>	
		(Telephone) <u>(216) 274-6514</u> Fax # <u>(248) 233-7349</u>	
		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 Village Hlthcare Ctr

0042671 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,084</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>19,032</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>46,116</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>6,434</u>	<u>395</u>	<u>4,203</u>	<u>11,032</u>
9	SNF/PED				
10	ICF	<u>12,437</u>	<u>1,907</u>	<u>7</u>	<u>14,351</u>
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>18,871</u>	<u>2,302</u>	<u>4,210</u>	<u>25,383</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.04%

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)
N/A

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/97 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 53 and days of care provided 3,641

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 Village Hlthcare Ctr # 0042671 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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	172,772	31,833	7,270	211,875		211,875	83	211,958			1
2	Food Purchase		192,566		192,566		192,566	61	192,627			2
3	Housekeeping	128,470	22,042	235	150,747		150,747	725	151,472			3
4	Laundry	50,165	15,557		65,722		65,722		65,722			4
5	Heat and Other Utilities			121,523	121,523		121,523	(19,531)	101,992			5
6	Maintenance	92,357	51,910	7,455	151,722		151,722	13,564	165,286			6
7	Other (specify):*			22,772	22,772		22,772	2,185	24,957			7
8	TOTAL General Services	443,764	313,908	159,255	916,927		916,927	(2,913)	914,014			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,616,617	111,869	5,871	1,734,357		1,734,357		1,734,357			10
10a	Therapy	43,978		450,835	494,813		494,813		494,813			10a
11	Activities	27,968	2,723	204	30,895		30,895		30,895			11
12	Social Services	118,712		18,544	137,256		137,256		137,256			12
13	CNA Training											13
14	Program Transportation	5,613		60	5,673		5,673		5,673			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,812,888	114,592	492,014	2,419,494		2,419,494		2,419,494			16
	C. General Administration											
17	Administrative	192,434			192,434		192,434	10,387	202,821			17
18	Directors Fees											18
19	Professional Services			219,386	219,386		219,386	(132,750)	86,636			19
20	Dues, Fees, Subscriptions & Promotions			24,642	24,642		24,642	(5,761)	18,881			20
21	Clerical & General Office Expenses	80,039	43,402	4,005	127,446		127,446	50,259	177,705			21
22	Employee Benefits & Payroll Taxes			402,414	402,414		402,414		402,414			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,483	2,483		2,483	221	2,704			24
25	Other Admin. Staff Transportation			8,953	8,953		8,953	416	9,369			25
26	Insurance-Prop.Liab.Malpractice			202,089	202,089		202,089	9,704	211,793			26
27	Other (specify):*			17,021	17,021		17,021	(1,735)	15,286			27
28	TOTAL General Administration	272,473	43,402	880,993	1,196,868		1,196,868	(69,259)	1,127,609			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,529,125	471,902	1,532,262	4,533,289		4,533,289	(72,172)	4,461,117			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			37,597	37,597		37,597	87,692	125,289			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			297	297		297	70,976	71,273			32
33	Real Estate Taxes							38,219	38,219			33
34	Rent-Facility & Grounds			201,900	201,900		201,900	(201,900)				34
35	Rent-Equipment & Vehicles			20,103	20,103		20,103	152	20,255			35
36	Other (specify):*			1,724	1,724		1,724	9,806	11,530			36
37	TOTAL Ownership			261,621	261,621		261,621	4,945	266,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			148,400	148,400		148,400		148,400			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,234	206,234		206,234		206,234			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			354,634	354,634		354,634		354,634			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,529,125	471,902	2,148,517	5,149,544		5,149,544	(67,227)	5,082,317			45

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(20,325)	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	1,010	30		9
10	Interest and Other Investment Income	(40)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,724)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,521)	27		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	(61,722)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,822)		\$	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)	32,595		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,595		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (67,227)		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

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Prairie Village HC, LLC Management Fees	\$ (6,300) 17	1
2	Prairie Village HC, LLC Audit Expense	(13,050) 19	2
3	Prairie Village HC, LLC Bank Charges	(296) 21	3
4	Prairie Village HC, Filing Fees	(75) 21	4
5	Prairie Village HC, Amortization	(2,794) 31	5
6	Theft Losses	(25) 21	6
7	Collection Expenses	(879) 21	7
8	PAC Dues	(7,113) 20	8
9	PPP Consulting	(1,800) 19	9
10	Non-Allowable Expense	(29,390) 21	10
11		0	11
12		0	12
13		0	13
14		0	14
15		0	15
16		0	16
17		0	17
18		0	18
19		0	19
20		0	20
21		0	21
22		0	22
23		0	23
24		0	24
25		0	25
26		0	26
27		0	27
28		0	28
29		0	29
30		0	30
31		0	31
32		0	32
33		0	33
34		0	34
35		0	35
36		0	36
37		0	37
38		0	38
39		0	39
40		0	40
41		0	41
42		0	42
43		0	43
44		0	44
45		0	45
46		0	46
47		0	47
48		0	48
49	Total	(61,722)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	83	0	0	0	0	0	0	0	0	83	1
2	Food Purchase	0	0	61	0	0	0	0	0	0	0	0	61	2
3	Housekeeping	0	0	725	0	0	0	0	0	0	0	0	725	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	794	0	0	0	0	0	0	0	0	794	5
6	Maintenance	0	0	1,582	11,982	0	0	0	0	0	0	0	13,564	6
7	Other (specify):*	0	0	0	2,185	0	0	0	0	0	0	0	2,185	7
8	TOTAL General Services	0	0	3,245	14,167	0	0	0	0	0	0	0	17,412	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(6,300)	6,300	0	10,387	0	0	0	0	0	0	0	10,387	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,850)	13,050	(130,950)	0	0	0	0	0	0	0	0	(132,750)	19
20	Fees, Subscriptions & Promotions	(7,113)	0	1,352	0	0	0	0	0	0	0	0	(5,761)	20
21	Clerical & General Office Expenses	(30,665)	371	7,121	73,432	0	0	0	0	0	0	0	50,259	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	221	0	0	0	0	0	0	0	0	221	24
25	Other Admin. Staff Transportation	0	0	416	0	0	0	0	0	0	0	0	416	25
26	Insurance-Prop.Liab.Malpractice	0	8,813	891	0	0	0	0	0	0	0	0	9,704	26
27	Other (specify):*	0	0	0	15,286	0	0	0	0	0	0	0	15,286	27
28	TOTAL General Administration	(58,928)	28,534	(120,949)	99,105	0	0	0	0	0	0	0	(52,238)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,928)	28,534	(117,704)	113,272	0	0	0	0	0	0	0	(34,826)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,010	85,284	1,398	0	0	0	0	0	0	0	0	87,692	30
31	Amortization of Pre-Op. & Org.	(2,794)	2,794	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	66,018	4,998	0	0	0	0	0	0	0	0	71,016	32
33	Real Estate Taxes	0	35,437	2,782	0	0	0	0	0	0	0	0	38,219	33
34	Rent-Facility & Grounds	0	(201,900)	0	0	0	0	0	0	0	0	0	(201,900)	34
35	Rent-Equipment & Vehicles	0	0	152	0	0	0	0	0	0	0	0	152	35
36	Other (specify):*	0	11,530	0	0	0	0	0	0	0	0	0	11,530	36
37	TOTAL Ownership	(1,784)	(837)	9,330	0	0	0	0	0	0	0	0	6,709	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(60,712)	27,697	(108,374)	113,272	0	0	0	0	0	0	0	(28,117)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 201,900	Prairie Village Healthcare Center, LLC	100.00%	\$	(201,900)	1
2	V	32	Interest	23	Prairie Village Healthcare Center, LLC	100.00%	66,041	66,018	2
3	V	17	Management Fees		Prairie Village Healthcare Center, LLC	100.00%	6,300	6,300	3
4	V	19	Audit Fees		Prairie Village Healthcare Center, LLC	100.00%	13,050	13,050	4
5	V	21	Bank & Filing Charges		Prairie Village Healthcare Center, LLC	100.00%	371	371	5
6	V	30	Depreciation		Prairie Village Healthcare Center, LLC	100.00%	85,284	85,284	6
7	V	31	Amortization		Prairie Village Healthcare Center, LLC	100.00%	2,794	2,794	7
8	V	33	Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	35,437	35,437	8
9	V	26	Insurance Expense		Prairie Village Healthcare Center, LLC	100.00%	8,813	8,813	9
10	V	36	MIP Expense		Prairie Village Healthcare Center, LLC	100.00%	11,530	11,530	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 201,923			\$ 229,620	\$ * 27,697	14

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

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	Sherwin Ray	33.33%	BEECHER MANOR NURSING AND REHABIL	BEECHER	Ex Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	BURBANK REHABILITATION CENTER	BURBANK	Ex . Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	CHATEAU NURSING AND REHABILITATION	WILLOWBROOK	2201 Main Street	Evanston, IL	Bldg. Company	3
4			COUNTRYSIDE NURSING AND REHABILITATION	DOLTON	CCS VEBA	Evanston, IL	Health Insurance	4
5			GRASMERE PLACE, LLC	CHICAGO	Vent Lease	Evanston, IL	Vent. Rental	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			LAKEWOOD NURSING & REHABILITATION	PLAINFIELD	Prairie Village	Jacksonville, IL	Bldg. Company	7
8			LEMONT NURSING AND REHABILITATION	LEMONT	Healthcare CTR			8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH	(MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION	CHICAGO HEIGHTS				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REH	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC	CAMP POINT				24
25			WESTMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting	100.00%	\$ 83	\$	83
16	V	02	Food		Extended Care Consulting	100.00%	61		61
17	V	03	Housekeeping		Extended Care Consulting	100.00%	725		725
18	V	05	Utilities		Extended Care Consulting	100.00%	794		794
19	V	06	Maintenance		Extended Care Consulting	100.00%	1,582		1,582
20	V	17	Administrative		Extended Care Consulting	100.00%	0		
21	V	19	Professional Fees		Extended Care Consulting	100.00%	3,234		3,234
22	V	20	Dues and Subscriptions		Extended Care Consulting	100.00%	1,352		1,352
23	V	21	Office and Clerical		Extended Care Consulting	100.00%	7,121		7,121
24	V	24	Seminar and Travel		Extended Care Consulting	100.00%	221		221
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting	100.00%	416		416
26	V	26	Insurance		Extended Care Consulting	100.00%	891		891
27	V	30	Depreciation		Extended Care Consulting	100.00%	1,398		1,398
28	V	32	Interest		Extended Care Consulting	100.00%	4,998		4,998
29	V	33	Real Estate Taxes		Extended Care Consulting	100.00%	2,782		2,782
30	V	34	Rent - Building		Extended Care Consulting	100.00%	0		
31	V	35	Rent - Equipment		Extended Care Consulting	100.00%	152		152
32	V	19	Consulting Fees	134,184	Extended Care Consulting	100.00%			(134,184)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 134,184			\$ 25,810	\$ *	(108,374)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salaries	\$	Extended Care Consulting	100.00%	\$ 11,982	\$ 11,982	15
16	V	06	Maintenance (Direct)		Extended Care Consulting	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting	100.00%	2,185	2,185	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting	100.00%			20
21	V	17	Administrative Salaries		Extended Care Consulting	100.00%	10,387	10,387	21
22	V	21	Office and Clerical Salaries		Extended Care Consulting	100.00%	73,432	73,432	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting	100.00%	15,286	15,286	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 113,272	\$ * 113,272	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	\$ 162,736	CCS VEBA	100.00%	\$ 162,736	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 162,736			\$ 162,736	\$ *	39

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

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	Adam Vales	Relative	Clerical	0.00%	See Attached	0.81	2.03%	Alloc Salary	\$ 1,447	22-07	1
2	Sherwin Ray	Owner	Administrative	33.33%	See Attached	5.50	13.75%	Salary	27,504	17-1	2
3	Jacob Bakst	Owner	Administrative	33.33%	See Attached	14.00	35.00%	Salary	52,500	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 81,451		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 Village Hlthcare Ctr # 0042671 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 ☒

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

()

()

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Village Hlthcare Ctr# 0042671

Report Period Beginning:

1/1/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Extended Care Consulting LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 491-9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Resident Days	1,219,947	36	\$ 3,992	\$	25,383	\$ 83	1
2	02	Food	Resident Days	1,219,947	36	2,910		25,383	61	2
3	03	Housekeeping	Resident Days	1,219,947	36	34,856		25,383	725	3
4	05	Utilities	Resident Days	1,219,947	36	38,173		25,383	794	4
5	06	Maintenance	Resident Days	1,219,947	36	76,040		25,383	1,582	5
6	17	Administrative	Resident Days	1,219,947	36			25,383		6
7	19	Professional Fees	Resident Days	1,219,947	36	155,408		25,383	3,234	7
8	20	Dues and Subscriptions	Resident Days	1,219,947	36	64,998		25,383	1,352	8
9	21	Office and Clerical	Resident Days	1,219,947	36	342,251		25,383	7,121	9
10	24	Seminar and Travel	Resident Days	1,219,947	36	10,602		25,383	221	10
11	25	Other Staff Admin. Trans.	Resident Days	1,219,947	36	19,988		25,383	416	11
12	26	Insurance	Resident Days	1,219,947	36	42,836		25,383	891	12
13	30	Depreciation	Resident Days	1,219,947	36	67,209		25,383	1,398	13
14	32	Interest	Resident Days	1,219,947	36	240,208		25,383	4,998	14
15	33	Real Estate Taxes	Resident Days	1,219,947	36	133,701		25,383	2,782	15
16	34	Rent - Building	Resident Days	1,219,947	36			25,383		16
17	35	Rent - Equipment	Resident Days	1,219,947	36	7,304		25,383	152	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,240,476	\$		\$ 25,810	25

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

1/1/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Extended Care Consulting LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 491-9565

	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	06	Maintenance Salaries	Resident Days	1,219,947	36	\$ 575,856	\$ 575,856	25,383	\$ 11,982	1
2	06	Maintenance (Direct)								2
3	07	Emp. Ben. - Gen. Serv.	Resident Days	1,219,947	36	105,021		25,383	2,185	3
4	07	Emp. Ben. - Gen. Serv. (Direct)								4
5	12	Admission (Direct)								5
6	15	Emp. Ben. - Nursing (Direct)								6
7	17	Administrative Salaries	Resident Days	1,219,947	36	499,202	499,202	25,383	10,387	7
8	21	Office and Clerical Salaries	Resident Days	1,219,947	36	3,529,267	3,529,267	25,383	73,432	8
9	21	Office and Clerical (Direct)								9
10	27	Emp. Ben. - Gen. Admin.	Resident Days	1,219,947	36	734,685		25,383	15,286	10
11	27	Emp. Ben. - Gen. Admin. (Direct)								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					\$ 5,444,030	\$ 4,604,325		\$ 113,272	25

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

1/1/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

CCS VEBA

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 491-9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocation	8,032,049		\$ 8,032,049	\$	162,736	\$ 162,736	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					\$ 8,032,049	\$		\$ 162,736	25

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	Cambridge Realty Capital		X	Mortgage	\$10,030.06	4/21/2016	\$ 2,334,000	\$ 2,071,561			\$ 66,041	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated From ECC		X								4,998	6
7	ECC- Line of Credit		X	Line of Credit				1,118,823				7
8	Auto Loan		X	Auto Loan							35	8
9	TOTAL Facility Related				\$10,030.06		\$ 2,334,000	\$ 3,190,384			\$ 71,074	9
	B. Non-Facility Related*											
10	Interest Income		X								(40)	10
11	Interest Income- Building		X								(23)	11
12	Long Term Rx Pharmacy		X								262	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 199	14
15	TOTALS (line 9+line14)						\$ 2,334,000	\$ 3,190,384			\$ 71,273	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,530 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$	33,636	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.)		\$	36,468	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,832	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	35,379	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.)		\$	8	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.		\$	38,219	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	25,167	8	
		2016	25,478	9	
		2017	31,332	10	
		2018	32,034	11	
		2019	33,694	12	
2020 Accrual: \$33,694 X 1.05 = \$35,379					
Allocated From ECC: \$2,782					

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.

FACILITY NAME Prairie Village Hlthcare Ctr COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0042671

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628 - 8784 FAX #: (248) 327-8417

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.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? ☐ (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? ☒ (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>8,686</u>	<u>1997</u>	<u>\$ 170,000</u>	<u>1</u>
2	<u>Allocated From ECC</u>			<u>11,570</u>	<u>2</u>
3	TOTALS	8,686		\$ 181,570	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	126		1997		\$ 1,114,539	\$	40	\$ 27,863	\$ 27,863	\$ 668,723	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Facility Improvements										10
11	Various			2002	4,490		20	225	225	4,266	11
12	Various			2003	13,083		20	654	654	11,775	12
13	Various			2004	5,343		20	267	267	4,542	13
14	Various			2005	4,475		20	224	224	3,580	14
15	Various			2006	13,021		20	651	651	9,766	15
16	Various			2007	7,421		20	371	371	5,195	16
17	Various			2009	11,377		20	569	569	6,826	17
18	Various			2010	7,607		20	380	380	4,184	18
19	Various			2011	9,432		20	472	472	4,716	19
20	Various			2012	25,784		20	1,289	1,289	11,603	20
21	Various			2014	20,208		20	1,010	1,010	7,073	21
22	Boiler and Pump			2015	15,677		20	784	784	4,703	22
23	Addition - Carpentry, Millwork, Steel, Drywall, Concrete, Roofing,										23
24	Doors, Windows, Painting, Flooring, HVAC, Plumbing, Electrical,										24
25	Fire Alarm, Partitions			2015	76,895		20	3,845	3,845	23,069	25
26	Security System			2016	4,080		20	204	204	1,020	26
27	Compressors			2016	18,788		20	939	939	4,697	27
28	Double Doors - Remove and Replace			2017	6,058		20	303	303	1,212	28
29	Electrical Panel - Transfer Switch and Breakers			2017	10,213		20	511	511	2,043	29
30	Water Heater			2018	6,477		20	324	324	972	30
31	Concrete Pad - Patio (Life Safety Code)			2018	4,000		20	200	200	600	31
32	Facility Driveway Repavement- Asphalt/Trap Rock- Rolled and Compacted			2019	10,794		20	540	540	1,079	32
33	Chiller- Compressor Replacement With Electrical Work			2019	7,066		20	353	353	707	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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	Prairie Village Healthcare Center, LLC Improvements								38
39	Various	1997	487,113		20			487,113	39
40	Various	1998	185,832		20			185,832	40
41	Various	1999	3,549		20			3,549	41
42	Various	2000	9,164		20			9,164	42
43	Various	2001	54,531		20	2,727	2,727	54,531	43
44	Various	2008	134,167		20	6,708	6,708	87,209	44
45	Various	2009	63,595		20	3,180	3,180	38,157	45
46	Various	2010	14,295		20	715	715	7,862	46
47	Various	2014	806,000		20	40,300	40,300	282,100	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Financial Statement Depreciation- Prairie Village Healthcare Center			37,597			(37,597)		63
64	Financial Statement Depreciation- Prairie Village HC Center LLC			85,284			(85,284)		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,155,074	\$ 122,881		\$ 95,607	\$ (27,274)	\$ 1,937,864	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,155,074	\$ 122,881		\$ 95,607	\$ (27,274)	\$ 1,937,864	1
2									2
3	Related Party Allocations								3
4									4
5	Dyer Building Allocations	2007	4,994	111	40	111		1,493	5
6	Allocated From ECC/2201 Main	2002	15,944	409	40	409		7,478	6
7									7
8									8
9	Allocated From ECC/2201 Main	2002	13,171		20			13,171	9
10	Allocated From ECC/2201 Main	2003	15,521		20			15,521	10
11	Allocated From ECC/2201 Main	2005	771		20			771	11
12	Allocated From ECC/2201 Main	2009	139	7	20	7		83	12
13	Allocated From ECC/2201 Main	2014	1,336	67	20	67		467	13
14	Allocated From ECC/2201 Main	2015	219	11	20	11		142	14
15	Allocated From ECC/2201 Main	2016	867	43	20	43		217	15
16	Allocated From ECC/2201 Main	2017	1,503	75	20	75		301	16
17	Allocated From ECC/2201 Main	2018	689	34	20	34		103	17
18	Allocated From ECC/2201 Main	2019	260	13	20	13		26	18
19	Allocated From ECC/2201 Main	2020	69	3	20	3		3	19
20									20
21									21
22	Allocated From ECC	2007	96	5	20	5		67	22
23	Allocated From ECC	2009	57	3	20	3		34	23
24	Allocated From ECC	2010	561	28	20	28		309	24
25	Allocated From ECC	2011	202	10	20	10		101	25
26	Allocated From ECC	2012	67	3	20	3		30	26
27	Allocated From ECC	2014	923	46	20	46		323	27
28	Allocated From ECC	2016	1,106	55	20	55		277	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	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
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	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 TOTAL (lines 1 thru 33)		\$ 3,213,569	\$ 123,804		\$ 96,530	\$ (27,274)	\$ 1,978,781	34

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

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	\$ 282,837	\$	\$ 28,284	\$ 28,284	10	\$ 169,703	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	133,215				10	133,215	73
74	See Attached	137,133	474	474		10	136,725	74
75	TOTALS	\$ 553,185	\$ 474	\$ 28,758	\$ 28,284		\$ 439,643	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	Facility	Van	2015	\$ 58,932	\$	\$	\$	5	\$ 58,932	76
77	Allocated From ECC		2014	530					530	77
78										78
79										79
80	TOTALS			\$ 59,462	\$	\$	\$		\$ 59,462	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,007,786	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,278	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,288	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,010	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,477,886	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.

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: *

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: \$ 20,255
- Description: \$3,665 Copier; \$7,550 Laundry;\$1,606 Water Treatment;\$173 Postage,\$7,109 Maint.;\$152 Alloc-ECC
- (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.

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

☒ 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)	\$			

- (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.

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	

- (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	V10A	hrs	\$	2,940	\$	220,488	\$	2,940	\$	220,488	1			
2	Licensed Speech and Language Development Therapist	V10A	hrs		331		24,825		331		24,825	2			
3	Licensed Recreational Therapist	V10A	hrs									3			
4	Licensed Physical Therapist	V10A	hrs		2,740		205,521		2,740		205,521	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation	V39	hrs		43,978						43,978	8			
9	Pharmacy	V39	# of prescripts					124,886			124,886	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Other (specify): LAB/RADIOLOGY	V39						23,514			23,514	12			
13	Other (specify): BILLABLE SUPPLIES	V39										13			
14	TOTAL			\$	43,978	6,011	\$	450,834	\$	148,400	6,011	\$	643,212	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 853,797	\$ 1,026,240	1
2	Cash-Patient Deposits	70,791	70,791	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	908,252	908,252	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,437	86,403	6
7	Other Prepaid Expenses	3,150	3,150	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	55	142,675	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,908,482	\$ 2,237,512	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,114,539	14
15	Leasehold Improvements, at Historical Cost	267,062	2,025,308	15
16	Equipment, at Historical Cost	364,416	433,416	16
17	Accumulated Depreciation (book methods)	(449,077)	(1,922,772)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		68,912	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	370,449	370,449	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 552,850	\$ 2,259,853	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,461,332	\$ 4,497,364	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 356,630	\$ 356,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,678	65,678	28
29	Short-Term Notes Payable	1,118,823	1,118,823	29
30	Accrued Salaries Payable	89,720	89,720	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,038	2,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)		35,379	32
33	Accrued Interest Payable		5,438	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	82,554	82,554	36
37	See Attached	696,896	696,896	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,412,339	\$ 2,453,158	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,071,561	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached			43
44	See Attached	384,883	384,883	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 384,883	\$ 2,456,444	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,797,222	\$ 4,909,602	46
47	TOTAL EQUITY (page 18, line 24)	\$ (335,890)	\$ (412,238)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,461,332	\$ 4,497,364	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,139,774)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,139,774)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,803,884	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,803,884	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)	\$ (335,890)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Prairie Village Hlthcare Ctr**# **0042671**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.****1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,126,621	1
2	Discounts and Allowances for all Levels	(1,801,565)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,325,056	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,447,508	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,447,508	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	272,553	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,109	19
20	Radiology and X-Ray	8,710	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 305,372	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		875,452	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 875,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,953,428	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	916,927	31
32	Health Care	2,419,494	32
33	General Administration	1,196,868	33
	B. Capital Expense		
34	Ownership	261,621	34
	C. Ancillary Expense		
35	Special Cost Centers	148,400	35
36	Provider Participation Fee	206,234	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,149,544	40
41	Income before Income Taxes (line 30 minus line 40)**	1,803,884	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,803,884	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,457,546	44
45	Private Pay - Net Inpatient Revenue	467,694	45
46	Medicare - Net Inpatient Revenue	624,753	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(25,394)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(199,543)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,325,056	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,843	2,078	\$ 85,701	\$ 41.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,934	10,803	381,383	35.30	3
4	Licensed Practical Nurses	19,142	20,859	537,972	25.79	4
5	CNAs & Orderlies	35,334	36,846	586,402	15.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,401	43,978	18.32	8
9	Activity Director	1	8	74	9.25	9
10	Activity Assistants	2,481	2,646	27,894	10.54	10
11	Social Service Workers	5,258	5,701	118,712	20.82	11
12	Dietician					12
13	Food Service Supervisor	2,107	2,316	38,122	16.46	13
14	Head Cook	11,585	12,691	134,650	10.61	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,339	5,877	92,357	15.71	17
18	Housekeepers	11,003	12,260	128,470	10.48	18
19	Laundry	4,632	5,159	50,165	9.72	19
20	Administrator	3,120	3,433	192,434	56.05	20
21	Assistant Administrator					21
22	Other Administrative	2,977	3,212	80,039	24.92	22
23	Office Manager					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	2,002	2,139	25,159	11.76	31
32	Other Health Care(specify)	431	463	5,613	12.12	32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	119,269	128,892	\$ 2,529,125 *	\$ 19.62	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	145	\$ 7,270	V01-03	35
36	Medical Director	Monthly Fees	16,500	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	5,454	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	204	V11-03	44
45	Social Service Consultant	8	544	V12-03	45
46	Other(specify)				46
47	Psycho Social Consultant	Monthly Fees	18,000	V12-03	47
48					48
49	TOTAL (lines 35 - 48)	156	\$ 47,972		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
XIX. SUPPORT SCHEDULES

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning: 1/1/20

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Ending: 12/31/20

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Jerri Springer	Administrator	0.00%	\$ 112,430	Workers' Compensation Insurance		\$ 105,927	IDPH License Fee	\$ 1,990
Sherwin Ray	Administrative	33.33%	27,504	Unemployment Compensation Insurance		10,297	Advertising: Employee Recruitment	4,504
Jakob Bakst	Administrative	33.33%	52,500	FICA Taxes		183,864	Health Care Worker Background Check	700
				Employee Health Insurance		97,646	(Indicate # of checks performed 14)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	8,519
				Other Employee Welfare		1,192	Licenses and Fees	1,816
				Holiday Expense		3,186	Allocated From ECC	1,352
				Employee Testing		302		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 402,414	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Ability Network	Data Processing/Billing	\$ 11,086			\$	Out-of-State Travel	\$	
Matrix Care	Data Processing/Software	17,177						
National Data Care Corp	Resident Funds Management	2,042						
Propay	Payroll Processing	14,468				In-State Travel		
See Attached	Legal Services	3,968						
Marco Technologies	IT Consulting	1,330						
Curaspan	Discharge Consulting	3,638						
Touch Support	Business Processing	486				Seminar Expense	2,483	
Plante Moran	Accounting Services	24,000				Allocated From ECC	221	
Personnel Planners	Unemployment Consulting	1,427						
Sher LLP	PPP Consulting (Adjusted)	1,800						
See Supplemental Page 21		137,964				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)		
			\$ 219,386			TOTAL	\$ 2,704	

* Attach copy of IMRF notifications

**See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
XIX. SUPPORT SCHEDULES

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning: 1/1/20

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Ending: 12/31/20

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
IIT/Source Tech	IT Consulting		660					
Ron Cournaya	Cost Reporting		3,120					
Extended Care Consulting	Consulting Fees		134,184				In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 137,964	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

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. HCCI \$14,225

(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? 5-10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,147 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. N/A

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 206,234
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? No Indicate the amount. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
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. \$ N/A

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.