

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>0018044</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Prairieview Lutheran Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</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>403 North 4th Street</u> <u>Danforth</u> <u>60930</u> Number City Zip Code																									
County: <u>Iroquois</u>																									
Telephone Number: <u>815-269-2970</u> Fax # <u>815-269-2930</u>																									
HFS ID Number: _____																									
Date of Initial License for Current Owners: <u>2/14/74</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jeffrey Petersen</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Marcie Meents Kolberg</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>SKDO, PC</u> <u>1605 N Convent, Bourbonnais, IL 60914</u></td></tr><tr><td>(Telephone) <u>815-937-1997</u> Fax # <u>815-935-0360</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jeffrey Petersen</u>	(Title) <u>Administrator</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Marcie Meents Kolberg</u> <u>CPA</u>	(Firm Name & Address) <u>SKDO, PC</u> <u>1605 N Convent, Bourbonnais, IL 60914</u>	(Telephone) <u>815-937-1997</u> Fax # <u>815-935-0360</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Jeffrey Petersen</u>																								
	(Title) <u>Administrator</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) <u>Marcie Meents Kolberg</u> <u>CPA</u>																								
	(Firm Name & Address) <u>SKDO, PC</u> <u>1605 N Convent, Bourbonnais, IL 60914</u>																								
	(Telephone) <u>815-937-1997</u> Fax # <u>815-935-0360</u>																								
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>Jeffrey Petersen</u> Telephone Number: <u>815-269-2970</u> Email Address: _____																									

Facility Name & ID Number

Prairieview Lutheran Home

0018044

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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

	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	90	Skilled (SNF)	90	32,850	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	32,850	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,859	3,191	3,539	0	17,189	1,943	55	30,776	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,859	3,191	3,539		17,189	1,943	55	30,776	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

93.69%

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 NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

I. On what date did you start providing long term care at this location?

Date started 2/14/1974

J. Was the facility purchased or leased after January 1, 1978?

YES NO X

K. Was the facility certified for Medicare during the reporting year?

YES X NO If YES, enter certified beds.

number of certified beds 90

Medicare Intermediary Wisconsin Physicans Service

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year?

YES X NO

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	666,217	34,664	23,779	724,660		724,660		724,660			1
2	Food Purchase		365,594		365,594		365,594	(24,339)	341,255			2
3	Housekeeping	233,918	37,223	496	271,637		271,637		271,637			3
4	Laundry	131,663	15,855	9,414	156,932		156,932		156,932			4
5	Heat and Other Utilities			152,038	152,038		152,038	(16,690)	135,348			5
6	Maintenance	152,968	11,509	113,834	278,311		278,311		278,311			6
7	Other (specify):*											7
8	TOTAL General Services	1,184,766	464,845	299,561	1,949,172		1,949,172	(41,029)	1,908,143			8
	B. Health Care and Programs											
9	Medical Director					1,400	1,400		1,400			9
10	Nursing and Medical Records	4,062,732	299,395	225,189	4,587,316	(70,758)	4,516,558		4,516,558			10
10a	Therapy	282,327		150	282,477		282,477		282,477			10a
11	Activities	309,845	5,487	39	315,371		315,371		315,371			11
12	Social Services	53,044		4,227	57,271		57,271		57,271			12
13	CNA Training	23,884	338		24,222		24,222		24,222			13
14	Program Transportation	20,126		2,901	23,027		23,027		23,027			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,751,958	305,220	232,506	5,289,684	(69,358)	5,220,326		5,220,326			16
	C. General Administration											
17	Administrative	106,109			106,109		106,109		106,109			17
18	Directors Fees											18
19	Professional Services			60,112	60,112		60,112	(2,040)	58,072			19
20	Dues, Fees, Subscriptions & Promotions			29,352	29,352		29,352		29,352			20
21	Clerical & General Office Expenses	236,022	5,786	409,203	676,011	(1,400)	674,611	(42,680)	631,931			21
22	Employee Benefits & Payroll Taxes			1,461,072	1,461,072		1,461,072		1,461,072			22
23	Inservice Training & Education			5,914	5,914		5,914		5,914			23
24	Travel and Seminar			870	870		870		870			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,519	67,519		67,519		67,519			26
27	Other (specify):* golf outings			1,320	1,320		1,320	(1,320)				27
28	TOTAL General Administration	342,131	5,786	2,035,362	2,408,279	(1,400)	2,406,879	(46,040)	2,360,839			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,278,855	775,851	2,567,429	9,647,135	(70,758)	9,576,377	(87,069)	9,489,308			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			268,953	268,953		268,953		268,953			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144	144		144		144			32
33	Real Estate Taxes			6,493	6,493		6,493	(50)	6,443			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			275,590	275,590		275,590	(50)	275,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	23,063		275	23,338		23,338		23,338			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			466,501	466,501		466,501		466,501			42
43	Other (specify):* drugs/labs					70,758	70,758		70,758			43
44	TOTAL Special Cost Centers	23,063		466,776	489,839	70,758	560,597		560,597			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,301,918	775,851	3,309,795	10,412,564		10,412,564	(87,119)	10,325,445			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$ (2,040)	19	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,339)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,690)	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	(42,680)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,320)	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 real estate taxes	(50)	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,119)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (87,119)		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	x		5,708	10,2	42
43	Prescription Drugs	x		65,050	10,2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 70,758		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

☐ 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			\$			\$	\$	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.

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			\$			\$	\$	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			\$			\$ 0	\$ *	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Prairieview Lutheran Home			ID#		0018044			
Report Period Beginning:			1/1/2025					
Ending:			12/31/2025					
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)							Management	
-Owners of companies must be listed instead of company names.					Operator/Licensee		Building Co.	
-Names of trust beneficiaries must be listed.					Ownership Percentage		Ownership Percentage	
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Douglas	W	Benner	Woodland	IL	0.00000	0.00000	0.00000
2	Kim	M	Seggebruch	Onarga	IL	0.00000	0.00000	0.00000
3	Jerry	L	Henrichs	Millford	IL	0.00000	0.00000	0.00000
4	Joel	R	Brown	Crescent City	IL	0.00000	0.00000	0.00000
5	Marcia	L	Glenn	Ashkum	IL	0.00000	0.00000	0.00000
6	Patrick	M	Jenkins	Bourbonnais	IL	0.00000	0.00000	0.00000
7	Jody	L	Munsterman	Onarga	IL	0.00000	0.00000	0.00000
8	Charles	L	Bohlmann	Gilman	IL	0.00000	0.00000	0.00000
9	Judy	K	Witheft	Buckingham	IL	0.00000	0.00000	0.00000
10	Bernie	L	Henrichs	Clifton	IL	0.00000	0.00000	0.00000
11								
12								
13	Note: non of the board of directors receive any compensation.							
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
68								
69								
70								
71								
72								
73								
74								
75								

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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 Prairieview Lutheran Home # 0018044 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

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	Copier lease		x	copier equipment	\$683.95	4/2023	\$ 40,520	\$ 18,359	3/2028	0.0500	\$ 114	1	
2	Phone lease		x	phone equipment	\$396.00	10/2023	14,147	3,557	9/2026	0.0500	30	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$1,079.95		\$ 54,667	\$ 21,916			\$ 144	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 54,667	\$ 21,916			\$ 144	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.)

B. Real Estate Taxes

17	AMOUNT TO USE FOR RATE CALCULATION \$	17
----	---------------------------------------	----

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.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:49,200B. General Construction Type:ExteriorbrickFramesteel and brickNumber of Stories1
- 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).

Luther Place- 20 room assisted/indepnent living facility

- F. List the bed capacity for the building if it differs from the licensed total.na
- G. Have you properly capitalized all major repairs and equipment purchases?yes
- H. Are you presently operating under a sale and leaseback arrangement?no
If YES, give effective date of lease.
- I. Are you presently operating under a sublease agreement?no
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNOx If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

- K. 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:

1		2	3	4	
Use		Square Feet	Year Acquired	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:

1/1/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	58			1973	\$ 649,567	\$	40	\$		\$ 649,567	4	
5				1995	1,013,622	20,193	40	20,193		738,386	5	
6	32			1996	1,834,874	45,872	40	45,872		1,314,993	6	
7											7	
8											8	
	Improvement Type**											
9	Fully depreciated				1,357,648					1,357,648	9	
10					1,603,523	113,757	various	113,757		460,556	10	
11											11	
12	South parking lot resurfacing			2022	109,760	3,658	20	3,658		12,194	12	
13	Landscaping-trees at front of building			2022	14,793	739	20	739		2,587	13	
14											14	
15	7.5 ton RTU			2023	21,980	1,099	20	1,099		2,748	15	
16	Security camera system			2023	24,583	2,458	10	2,458		5,736	16	
17	Asphalt parking lot			2023	39,397	1,313	30	1,313		3,064	17	
18	Unimac dryer 55 lb			2023	5,467	547	10	547		1,322	18	
19	Water softener			2023	11,533	769	15	769		1,666	19	
20	Flooring in Faith Place			2023	24,260	1,213	20	1,213		2,426	20	
21	Aon unit compressor			2023	5,795	1,159	5	1,159		2,704	21	
22											22	
23	Family room remodel			2024	9,744	325	30	325		623	23	
24	Family room flooring			2024	4,812	481	10	481		922	24	
25	Family room patio			2024	6,880	344	20	344		516	25	
26	LVT flooring-100% of memory care unit (total unit)			2024	182,059	12,137	15	12,137		18,205	26	
27	Memory care unit remodel			2024	288,552	9,618	30	9,618		12,824	27	
28	LVT flooring-nursing home unit rooms 248, 326, 328			2024	5,995	400	15	400		400	28	
29	Navien NG Tankless water heaters			2024	45,012	2,251	20	2,251		2,626	29	
30	Lobby furniture			2024	7,970	1,594	5	1,594		1,726	30	
31	Call light system-memory care unit			2024	62,024	3,101	20	3,101		4,393	31	
32	Aaon unit			2024	59,950	1,998	30	1,998		2,498	32	
33	RTUs (Roof top units)			2024	80,475	2,682	30	2,682		3,576	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	Call light system-building wide	2025	86,230	2,874	15	2,874		2,874	38
39	LVT flooring (235-243; 246, 247, 250, 324,, 325, 327, 329, 331-333	2025	45,840	2,292	15	2,292		2,292	39
40	335-337, 339-341, 419, 423, 424, 428, 429)	2025							40
41	Hybrid tankless water heaters in memory care unit	2025	38,922	1,622	20	1,622		2,622	41
42	Remodeling in memory care unit	2025	23,512	457	30	457		457	42
43	Walking path-outside of building	2025	47,542	1,585	10	1,585		1,585	43
44	2 sewerage pumps	2025	18,267	761	20	761		761	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,730,588	\$ 237,299		\$ 237,299	\$	\$ 4,614,497	70

**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	\$ 333,811	\$ 26,746	\$ 26,746	\$	various	\$ 168,294	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	595,641					595,641	73
74								74
75	TOTALS	\$ 929,452	\$ 26,746	\$ 26,746	\$		\$ 763,935	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 transpotation	2010 Ford Elkhart	2010	\$ 45,949	\$	\$	\$	10	\$ 45,949	76
77	resident transpotation	major report-Ford Elkhart	2013	2,261				10	2,261	77
78	resident transpotation	2022 Chrysler Vayager	2022	49,079	4,908	4,908		10	17,178	78
79										79
80	TOTALS			\$ 97,289	\$ 4,908	\$ 4,908	\$		\$ 65,388	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)	\$ 8,766,444	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 268,953	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 268,953	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)	\$ 5,443,820	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: _____
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: \$ _____ 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.

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.	_____/2026	\$ _____
13.	_____/2027	\$ _____
14.	_____/2028	\$ _____

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

☒

☐

☐

102

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		338		338
3	Classroom Wages (a)		17,156		17,156
4	Clinical Wages (b)		6,728		6,728
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 24,222	\$	\$ 24,222
10	SUM OF line 9, col. 1 and 2 (e)	\$ 24,222			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(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.)

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a, 1	1078	hrs	\$ 11,363		\$	\$	1,078	\$ 11,363	1	
2	Licensed Speech and Language Development Therapist	10a, 1	105	hrs	13,442				105	13,442	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a,1	3022	hrs	111,610				3,022	111,610	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				\$ 136,415		\$	\$	4,205	\$ 136,415	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 258,929	\$	1
2	Cash-Patient Deposits	11,016		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	376,703		3
4	Supply Inventory (priced at cost)	64,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	121,170		6
7	Other Prepaid Expenses	3,568		7
8	Accounts Receivable (owners or related parties)	84,784		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 920,929	\$	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	7,436,122		14
15	Leasehold Improvements, at Historical Cost	303,581		15
16	Equipment, at Historical Cost	1,026,741		16
17	Accumulated Depreciation (book methods)	(5,443,820)		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)	\$ 3,331,739	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,252,668	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 309,806	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,016		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	437,040		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	Resident security deposit	1,200		36
37	Deferred revenue	94,883		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 853,945	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,916		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 21,916	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 875,861	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,376,807	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,252,668	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,509,220	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,509,220	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,413)	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)	\$ (132,413)	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)	\$ 3,376,807	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Prairieview Lutheran Home**# **0018044**Report Period Beginning: **1/1/2025**Ending: **12/31/2025**

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	\$ 11,534,376	1
2	Discounts and Allowances for all Levels	(1,774,238)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,760,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	69,966	6
7	Oxygen	7,820	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 77,786	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	29,656	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)	\$ 29,656	23
	D. Non-Operating Revenue		
24	Contributions	346,057	24
25	Interest and Other Investment Income***	1,284	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 347,341	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Finance charges	3,314	28
28a	Miscellaneous income	61,916	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,230	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,280,151	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,949,172	31
32	Health Care	5,289,684	32
33	General Administration	2,408,279	33
	B. Capital Expense		
34	Ownership	275,590	34
	C. Ancillary Expense		
35	Special Cost Centers	23,338	35
36	Provider Participation Fee	466,501	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,412,564	40
41	Income before Income Taxes (line 30 minus line 40)**	(132,413)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (132,413)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,061,662.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	717,184.00	45
46	MMAI-Medicaid is the Primary Payer	795,505.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	5,926,805.00	48
49	Medicare Part A	1,158,579.00	49
50	Other-(specify) Medicare B	100,403.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,760,138	56

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	1,816	2,080	\$ 99,235	\$ 47.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,160	19,625	822,641	41.92	3
4	Licensed Practical Nurses	21,236	22,997	854,582	37.16	4
5	CNAs & Orderlies	93,318	99,412	2,138,740	21.51	5
6	CNA Trainees	1,502	1,502	23,884	15.90	6
7	Licensed Therapist	2,746	2,897	136,415	47.09	7
8	Rehab/Therapy Aides	3,388	3,628	144,353	39.79	8
9	Activity Director	1,728	1,879	44,132	23.49	9
10	Activity Assistants	14,657	15,203	239,240	15.74	10
11	Social Service Workers	1,670	1,872	51,030	27.26	11
12	Dietician					12
13	Food Service Supervisor	1,732	2,072	74,620	36.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,760	35,134	593,170	16.88	15
16	Dishwashers					16
17	Maintenance Workers	5,128	5,719	152,644	26.69	17
18	Housekeepers	13,864	14,720	248,215	16.86	18
19	Laundry	6,544	6,992	121,376	17.36	19
20	Administrator	1,482	1,664	110,374	66.33	20
21	Assistant Administrator					21
22	Other Administrative	6,936	7,737	269,169	34.79	22
23	Office Manager					23
24	Clerical	3,145	3,238	59,330	18.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care memory care direct	1,888	2,080	75,317	36.21	32
33	Other(specify) <u>van driver/beautician</u>	2,147	2,230	43,451	19.48	33
34	TOTAL (lines 1 - 33)	236,847	252,681	\$ 6,301,918 *	\$ 24.94	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	141	\$ 9,429	1, 3	35
36	Medical Director		1,400	9, 8	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,819	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	48	3,902	12, 3	45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	189	\$ 25,550		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	814	\$ 52,065	20.3	50
51	Licensed Practical Nurses	1,661	98,378	20.3	51
52	Certified Nurse Assistants/Aides	1,657	61,805	20.3	52
53	TOTAL (lines 50 - 52)	4,132	\$ 212,248		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
0018044

Report Period Beginning: 1/1/2025

Page 21
Ending: 12/31/2025

Prairieview Lutheran Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Jeffrey Peterson

administrator

0

\$ 106,109

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 106,109

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

Borshnack Pelletier

auditor

\$ 14,196

SKDO PC

CPA outside accountant

38,522

Thomas Malmer

attorney

3,915

Ralph Rorem

architect

3,160

IDPH

memory care remodel approval

319

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 60,112

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 69,931

Unemployment Compensation Insurance

FICA Taxes

464,864

Employee Health Insurance

837,455

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401K contributions

49,919

Employee life insurance

10,559

Health savings contributions

28,344

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,461,072

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

\$

Advertising: Employee Recruitment

14,184

Health Care Worker Background Check

4,631

(Indicate # of checks performed 95)

Patient Background Checks

63

Association Dues (total from pg 22, #4)

2,200

Dues and Fees

7,707

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 29,352

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

no
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
Other, please specify	
Lutheran Services of America	2,200
	2,200
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Other, please specify	
Lutheran Services of America	
	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

Other, please specify	
Lutheran Services of America	2,200
	2,200
	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 85,131

Line 10.2
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 446,501

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

Has any meal income been offset against related costs?

yes

Indicate the amount.

\$ 24,339
- (12)

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?

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: Borschnack Pelletier and Co

yes
- (14)

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

yes
- (15)

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.