

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0046011

Facility Name: Prairie Manor Nursing & Rehab Center

Address: 345 Dixie Hwy Chicago Heights 60491
Number City Zip Code

County: Cook

Telephone Number: (708) 754-7601 Fax # (708) 754-8904

HFS ID Number:

Date of Initial License for Current Owners: 12/01/02

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	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>148</u>	Skilled (SNF)	<u>148</u>	<u>54,168</u>	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	<u>148</u>	TOTALS	<u>148</u>	<u>54,168</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>24,872</u>	<u>7,956</u>	<u>13,500</u>	<u>46,328</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,872</u>	<u>7,956</u>	<u>13,500</u>	<u>46,328</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.53%

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

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

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

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

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 12/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/01/2002 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 148 and days of care provided 12,846

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12
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	308,243	37,520	15,185	360,948		360,948	9,704	370,652			1
2	Food Purchase		243,833		243,833		243,833	51	243,884			2
3	Housekeeping	238,785	39,829		278,614		278,614	578	279,192			3
4	Laundry	97,251	13,434		110,685		110,685		110,685			4
5	Heat and Other Utilities			163,715	163,715		163,715	837	164,552			5
6	Maintenance	117,872		180,930	298,802		298,802	(4,251)	294,551			6
7	Other (specify):*							3,503	3,503			7
8	TOTAL General Services	762,151	334,616	359,830	1,456,597		1,456,597	10,422	1,467,019			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,955,409	253,510	10,147	3,219,066		3,219,066	53,352	3,272,418			10
10a	Therapy	207,853			207,853		207,853		207,853			10a
11	Activities	177,417	32,738		210,155		210,155		210,155			11
12	Social Services	182,063			182,063		182,063	21,737	203,800			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,658	12,658			15
16	TOTAL Health Care and Programs	3,522,742	286,248	46,147	3,855,137		3,855,137	87,747	3,942,884			16
	C. General Administration											
17	Administrative	157,663			157,663		157,663	83,720	241,383			17
18	Directors Fees											18
19	Professional Services			695,777	695,777	(21,759)	674,018	(546,465)	127,553			19
20	Dues, Fees, Subscriptions & Promotions			44,502	44,502		44,502	(24,350)	20,152			20
21	Clerical & General Office Expenses	181,562	59,445	251,013	492,020		492,020	(101,201)	390,819			21
22	Employee Benefits & Payroll Taxes			861,061	861,061		861,061	(1,611)	859,450			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,814	5,814		5,814	1,673	7,487			24
25	Other Admin. Staff Transportation			2,553	2,553		2,553	798	3,351			25
26	Insurance-Prop.Liab.Malpractice			207,733	207,733		207,733	1,489	209,222			26
27	Other (specify):*							31,633	31,633			27
28	TOTAL General Administration	339,225	59,445	2,068,453	2,467,123	(21,759)	2,445,364	(554,314)	1,891,049			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,624,118	680,309	2,474,430	7,778,857	(21,759)	7,757,098	(456,146)	7,300,952			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			80,976	80,976		80,976	99,430	180,406			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							180,013	180,013			32
33	Real Estate Taxes			666,536	666,536	21,759	688,295	2,643	690,938			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles			2,291	2,291		2,291	736	3,027			35
36	Other (specify):*											36
37	TOTAL Ownership			1,181,803	1,181,803	21,759	1,203,562	(149,178)	1,054,385			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		732,275	1,331,267	2,063,542		2,063,542	(32,653)	2,030,889			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			284,797	284,797		284,797		284,797			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		732,275	1,616,064	2,348,339		2,348,339	(32,653)	2,315,686			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,624,118	1,412,584	5,272,297	11,308,999		11,308,999	(637,977)	10,671,022			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	\$		\$	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,544)	30		9
10	Interest and Other Investment Income	(43,370)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(410)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(275)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,000)	21		24
25	Fund Raising, Advertising and Promotional	(20,887)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,192)	20		28
29	Other-Attach Schedule	(55,685)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (332,363)		\$	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)	(305,614)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (305,614)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (637,977)		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

ID#

0046011

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized R&M	\$ (10,700)	6	1
2	Other Income	(23,670)	21	2
3	Jury Duty	(120)	10	3
4	Theft Loss	(944)	21	4
5	Collections	(10,253)	21	5
6	Filing Fee - Bldg. Co.	(250)	20	6
7	Amortization Expense - Bldg. Co.	(615)	36	7
8				8
9	COPE Dues	(4,588)	20	9
10	Non-allowable Legal	(4,534)	19	10
11	Convenience Fee	(10)	33	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	(55,685)		49

ID#0046011

Report Period Beginning:01/01/12

Ending:12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

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	(29,544)	120,800	6,705		1,469							99,430	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(43,370)	191,651	4,169		27,563							180,013	32
33	Real Estate Taxes	(10)		2,115		538							2,643	33
34	Rent-Facility & Grounds		(432,000)										(432,000)	34
35	Rent-Equipment & Vehicles			1,031				(295)					736	35
36	Other (specify):*	(615)	615											36
37	TOTAL Ownership	(73,539)	(118,934)	14,020		29,570		(295)					(149,178)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(10,994)	(21,635)		(23)			(32,653)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(10,994)	(21,635)		(23)			(32,653)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(332,363)	(118,684)	(324,722)	132,738	38,002	(10,994)	(21,930)		(23)			(637,977)	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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

☒ YES

☐ 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	Rental Income	\$ 432,000	Prairie Manor Healthcare Properties	100.00%	\$	(432,000)	1
2	V	32	Interest Income	185	Prairie Manor Healthcare Properties			(185)	2
3	V	20	Filing Fee		Prairie Manor Healthcare Properties		250	250	3
4	V	30	Depreciation Expense		Prairie Manor Healthcare Properties		120,800	120,800	4
5	V	36	Amortization Expense		Prairie Manor Healthcare Properties		615	615	5
6	V	32	Interest Expense		Prairie Manor Healthcare Properties		191,836	191,836	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 432,185			\$ 313,501	\$ * (118,684)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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, LLC	100.00%	\$ 241	\$	241
16	V	02	Food		Extended Care Consulting, LLC	100.00%	461		461
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	461		461
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	667		667
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,641		2,641
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,853		2,853
21	V	19	Professional Fees	367,488	Extended Care Consulting, LLC	100.00%	4,033		(363,455)
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,497		3,497
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,938		11,938
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	214		214
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	798		798
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	942		942
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,705		6,705
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,169		4,169
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,115		2,115
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,031		1,031
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 367,488			\$ 42,766	\$ *	(324,722)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 (Pooled)		Extended Care Consulting, LLC	100.00%	6,171	\$ 6,171	15
16	V	06	Maintenance (Direct)	8,241	Extended Care Consulting, LLC	100.00%	5,826	(2,415)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,134	1,134	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	802	802	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,359	13,359	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	93,768	93,768	22
23	V	21	Office and Clerical (Direct)	(1,130)	Extended Care Consulting, LLC	100.00%	569	1,699	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,682	19,682	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	78	78	25
26	V	22	Employee Benefits	1,540	Extended Care Consulting, LLC	100.00%		(1,540)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 8,651			\$ 141,389	\$ * 132,738	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	03	Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 117	\$ 117	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	170	170	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	52	52	17
18	V	19	Professional Fees	180,996	Extended Care Clinical, LLC	100.00%	2,520	(178,476)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	95	95	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,094	2,094	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,459	1,459	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	547	547	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,469	1,469	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	27,563	27,563	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	538	538	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,463	9,463	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,567	1,567	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	54,248	54,248	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	21,737	21,737	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	12,587	12,587	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	67,508	67,508	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,167	4,167	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,873	11,873	34
35	V	10	Nursing / Medical Record Salary	1,362	Extended Care Clinical, LLC	100.00%	586	(776)	35
36	V	12	Social Service / Admission Salary		Extended Care Clinical, LLC	100.00%			36
37	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	71	71	37
38	V	22	Employee Benefits	71	Extended Care Clinical, LLC	100.00%		(71)	38
39	Total			\$ 182,429			\$ 220,431	\$ * 38,002	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39	Ancillary Expense	39,268	Care Centers Health Systems, Inc.	100.00%	28,274	\$ (10,994)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 39,268			\$ 28,274	\$ * (10,994)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39	Ventilator Equipment	37,990	Vent Lease LLC	100.00%	16,355	\$ (21,635)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	295	Vent Lease LLC	100.00%		(295)	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			\$ 38,285			\$ 16,355	\$ * (21,930)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 192,480	\$ 192,480	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	192,480	CCS Employee Benefits Group	100.00%		(192,480)	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			\$ 192,480			\$ 192,480	\$ *	39

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	39	Ancillary Expense	2,639	Reliable Medical of the Midwest, LLC	100.00%	2,616	\$ (23)	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			\$ 2,639			\$ 2,616	\$ * (23)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$ *	39

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			\$			\$	\$ *	39

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	ADAM VALES ACCUM. TRUST	11.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	PRAIRIE MANOR PROPERTY, L	EVANSTON	BUILDING CO.	1
2	DANIEL ROTHNER ACCUM. TRUST	11.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKING	2
3	ERIC ROTHNER	1.000%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	KATHRYN VALES ACCUM. TRUST	11.000%	BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTEM	DES PLAINES	DIETARY & FOOD SUPPLY	4
5	KIMBERLY RICHMAN ACCUM. TRUST	11.000%	CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	MELISSA ROTHNER ACCUM. TRUST	11.000%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	6
7	NATHAN & SHIRLEY ROTHNER TRUST	22.000%	DEVON GABLES REHABILITATION CENTER	ARIZONA	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	7
8	RACHEL ROTHNER ACCUM. TRUST	11.000%	DYER NURSING & REHAB	DYER, IN	RELIABLE MEDICAL SUPPLY CO	DES PLAINES	MEDICAL SUPPLY	8
9	WILLIAM ROTHNER ACCUM. TRUST	11.000%	FOOTHILLS REHABILITATION CENTER LLC	ARIZONA				9
10			GOLDEN PLAINES REHABILITATION CENTER	KANSAS				10
11			GRASMERE PLACE, LLC	CHICAGO				11
12			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				12
13			HOMESTEAD NURSING & REAHB	LINCOLN, NE				13
14			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				14
15			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				15
16			LANCASTER MANOR	LINCOLN, NE				16
17			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				17
18			MCKINLEY HEALTH CARE CENTER	CANTON, OH				18
19			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				19
20			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24			SHEFFIELD MANOR	DYER, IN				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

VII. RELATED PARTIES
A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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	N/A	See Attached	1.65	4.13%	Alloc. Salary	\$ 3,019	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.06	5.56%	Alloc. Salary	10,636	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 13,655		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 Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

Ending: 12/31/12

(847) 905-3030

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	06	Maintenance (Pooled)	Patient Days	1,364,178	31	181,713	181,713	46,328	6,171	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		5,826	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		46,328	1,134	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			802	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	46,328	13,359	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	46,328	93,768	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		569	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		46,328	19,682	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			78	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					\$ 4,679,511	\$ 3,961,379		\$ 141,389	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Clinical, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	03	Housekeeping	Patient Days	611,520	14	\$ 1,549	\$	46,328	\$ 117	1
2	05	Utilities	Patient Days	611,520	14	2,241		46,328	170	2
3	06	Maintenance	Patient Days	611,520	14	691		46,328	52	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		46,328	2,520	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		46,328	95	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		46,328	2,094	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		46,328	1,459	7
8	26	Insurance	Patient Days	611,520	14	7,216		46,328	547	8
9	30	Depreciation	Patient Days	611,520	14	19,393		46,328	1,469	9
10	32	Interest	Patient Days	611,520	14	363,826		46,328	27,563	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		46,328	538	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	46,328	9,463	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		46,328	1,567	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	46,328	54,248	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	46,328	21,737	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		46,328	12,587	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	46,328	67,508	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	46,328	4,167	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		46,328	11,873	20
21	10	Nursing / Medical Record Salary	Direct Allocation			10,300	10,300		586	21
22	12	Social Service / Admission Salary	Direct Allocation			6,057	6,057			22
23	15	Emp. Ben. - Healthcare	Direct Allocation			2,077			71	23
24										24
25	TOTALS					\$ 2,919,416	\$ 2,090,347		\$ 220,431	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Care Centers Health Systems, Inc.
Street Address 200 Howard
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number (224) 612-5662
Fax Number (224) 612-5862

	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	39	Ancillary Expense	Direct Allocation					28,274	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				\$	\$		\$ 28,274	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Vent Lease, LLC
Street Address 2201 W. Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	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	39 Ventilator Equipment	Direct Allocation						16,355	1
	2	39 Other Ancillary	Direct Allocation							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				\$	\$		\$ 16,355	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	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 Health Insurance	Direct Allocation			\$	\$		\$ 192,480	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					\$	\$		\$ 192,480	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Reliable Medical of the Midwest, LLC
Street Address 200 Howard Avenue
City / State / Zip Code Des Plaines, Illinois 60018-5909
Phone Number (847) 566-0800
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	Ancillary Expense	Direct Allocation					2,616	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				\$	\$		\$ 2,616	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	First Choice		X	Mortgage			\$	3,566,690			\$	191,836	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Allocated From EC Consulting	X										4,169	6
7	Allocated from EC Clinical	X										27,563	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	3,566,690			\$	223,568	9
	B. Non-Facility Related*												
10	Interest Income		X									(43,370)	10
11	Interest Income - Bldg. Co.		X									(185)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(43,555)	14
15	TOTALS (line 9+line14)						\$	3,566,690			\$	180,014	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 - SUPPLEMENTAL SCHEDULE

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							\$					1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$					8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$					15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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 2011 report.			\$	384,013	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.)			\$	515,111	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$	131,098	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	538,081	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.			\$	21,759	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.			\$	690,938	7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2007	450,013	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2008	454,918	9																					
		2009	535,700	10																					
		2010	365,726	11																					
		2011	512,458	12																					
2012 Accrual \$512,458 x 1.05 = \$538,081																									
Allocated from Extended Care Consulting \$2,115																									
Allocated from Extended Care Clinical \$538																									

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Prairie Manor Nursing & Rehab Center</u>	COUNTY	<u>Cook</u>
---------------	---	--------	-------------

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>32-17-131-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>512,457.98</u>	\$ <u>512,457.98</u>
2. <u>See Attached</u>	<u>Alloc. From 2201 Main LLC</u>	\$ <u>127,119.67</u>	\$ <u>2,108.02</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>639,577.65</u>	\$ <u>514,566.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		55,133	3,749		3,749		33,601	68
69	Financial Statement Depreciation			80,976			(80,976)		69
70	TOTAL (lines 4 thru 69)		\$ 5,228,263	\$ 205,525		\$ 145,594	\$ (59,931)	\$ 1,469,878	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 5,228,263	\$ 205,525		\$ 145,594	\$ (59,931)	\$ 1,469,878	1
2	Fire Protected Ceiling Tiles	2009	4,237		20	212	212	847	2
3	Windows	2009	6,663		20	333	333	1,249	3
4	Windows	2009	5,196		20	260	260	953	4
5	Roof Repairs	2009	3,565		20	178	178	624	5
6	Replace Smoke Damper Motors	2009	11,153		20	2,231	2,231	7,621	6
7	Masonry And Concrete Repair	2009	12,500		20	625	625	1,927	7
8	Legat Architects	2010	5,486		20	274	274	754	8
9	Seal Floor/Walls Around Main Elevator	2010	3,450		20	173	173	374	9
10	Modulating Flue Gas Inducer System	2010	31,700		20	1,585	1,585	3,434	10
11	New Valve On Elevator	2010	4,200		20	210	210	438	11
12	23 New Doors	2011	17,500		20	875	875	1,458	12
13	Replace Staging Control For Chiller	2011	4,882		20	976	976	1,627	13
14	Drivit System On Exterior Walls	2011	59,310		20	2,966	2,966	3,954	14
15	Install Floor Alarm & Locks	2011	3,644		20	182	182	243	15
16	Modulating Flue Gas Inducer System	2011	5,651		20	283	283	353	16
17	Install New Hot Water Unit In Boiler Room	2011	8,800		20	440	440	477	17
18	Roof And Window Repair	2011	4,500		20	225	225	394	18
19	Replace Gypsum With Glass Boards	2012	29,840		20	1,492	1,492	1,492	19
20	Glass/Metal Store Front Construction	2012	20,465		20	853	853	853	20
21	Remove And Replace Concrete Slab In Dock Area	2012	10,500		20	88	88	88	21
22	Window Replacement	2012	2,850		20	131	131	131	22
23	Window Replacement	2012	2,850		20	119	119	119	23
24	Replace Concrete Slab - Handicap Ramp	2012	5,000		20	104	104	104	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)		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	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)		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	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)		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	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)		\$ 5,492,206	\$ 205,525		\$ 160,407	\$ (45,118)	\$ 1,499,391	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,936	383	39	383		3,942	3
4	Allocated from Extended Care Clinical, 2201 Main LLC	2002	3,802	98	39	98		1,003	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	156	8	20	8		47	9
10	Allocated from Extended Care Consulting	2009	93	5	20	5		19	10
11	Allocated from Extended Care Consulting	2010	916	46	20	46		137	11
12	Allocated from Extended Care Consulting	2011	330	16	20	16		33	12
13	Allocated from Extended Care Consulting	2012	109	5	20	5		5	13
14									14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2002	12,339	1,128	20	1,128		10,159	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2003	14,541	1,329	20	1,329		11,973	16
17	Allocated from Extended Care Consulting, 2201 Main LLC	2005	722	77	20	77		491	17
18	Allocated from Extended Care Consulting, 2201 Main LLC	2009	130	7	20	7		26	18
19									19
20	Allocated from Extended Care Clinical, 2201 Main LLC	2002	3,141	287	20	287		2,586	20
21	Allocated from Extended Care Clinical, 2201 Main LLC	2003	3,701	338	20	338		3,048	21
22	Allocated from Extended Care Clinical, 2201 Main LLC	2005	184	20	20	20		125	22
23	Allocated from Extended Care Clinical, 2201 Main LLC	2009	33	2	20	2		7	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Related Party Information Continued								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 (12H & 12I lines 1 thru 33)		\$ 55,133	\$ 3,749		\$ 3,749	\$	\$ 33,601	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 144,276	\$ 2,754	\$ 17,160	\$ 14,406	10	\$ 109,201	71
72	Current Year Purchases	15,064		1,168	1,168	10	1,168	72
73	Fully Depreciated Assets	1,498,341				10	1,498,341	73
74								74
75	TOTALS	\$ 1,657,681	\$ 2,754	\$ 18,328	\$ 15,574		\$ 1,608,710	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		Allocated from EC Consulting	2011	\$ 5,263	\$ 1,053	\$ 1,053		5	\$ 5,263	76
77		Allocated from EC Clinical	2011	3,892	620	620		5	372	77
78										78
79										79
80	TOTALS			\$ 9,155	\$ 1,673	\$ 1,673			\$ 5,635	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)	\$ 7,622,640	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 209,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,408	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,544)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,113,737	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	Architecture	\$ 123,177	92
93			93
94			94
95		\$ 123,177	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: \$ 3,027
- Description: See Attached Schedule

(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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 567,085	\$		\$ 567,085	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			166,666			166,666	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			665,349			665,349	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				590,430		590,430	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					(67,833)	141,845		74,012	13
14	TOTAL			\$		\$ 1,331,267	\$ 732,275		\$ 2,063,542	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 1,811	\$ 55,179	1
2	Cash-Patient Deposits	21,765	21,765	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,859,141	1,859,141	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	320,352	320,352	6
7	Other Prepaid Expenses	3,320	3,320	7
8	Accounts Receivable (owners or related parties)	533,271	533,271	8
9	Other(specify): See Attached Schedule	689,307	1,025,102	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,428,967	\$ 3,818,130	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,550,000	14
15	Leasehold Improvements, at Historical Cost	632,562	732,562	15
16	Equipment, at Historical Cost	422,717	1,622,717	16
17	Accumulated Depreciation (book methods)	(697,660)	(3,148,866)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		6,150	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,971)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	123,598	123,598	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 481,217	\$ 4,331,190	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,910,184	\$ 8,149,320	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,091,901	\$ 3,091,900	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,107	16,107	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	365,155	365,155	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,779	15,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)	538,081	538,081	32
33	Accrued Interest Payable		15,827	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	330	1,679,295	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,027,353	\$ 5,722,144	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,566,690	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,566,690	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,027,353	\$ 9,288,834	46
47	TOTAL EQUITY(page 18, line 24)	\$ (117,169)	\$ (1,139,514)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,910,184	\$ 8,149,320	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (565,696)	1
2	Restatements (describe):		2
3	Rouding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (565,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	948,525	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	(500,000)	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)	\$ 448,525	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)	\$ (117,169)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,019,111	1
2	Discounts and Allowances for all Levels	(6,142,873)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,876,238	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,520,948	6
7	Oxygen	366	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,521,314	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	3,238	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	619,416	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	88,453	19
20	Radiology and X-Ray	6,265	20
21	Other Medical Services	75,440	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 792,812	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43,370	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,370	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	23,790	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,790	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,257,524	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,456,597	31
32	Health Care	3,855,137	32
33	General Administration	2,467,123	33
	B. Capital Expense		
34	Ownership	1,181,803	34
	C. Ancillary Expense		
35	Special Cost Centers	2,063,542	35
36	Provider Participation Fee	284,797	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,308,999	40
41	Income before Income Taxes (line 30 minus line 40)**	948,525	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 948,525	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,535,911	44
45	Private Pay - Net Inpatient Revenue	1,219,612	45
46	Medicare - Net Inpatient Revenue	588,683	46
47	Other-(specify) Hospice	508,739	47
48	Other-(specify) Insurance, Veteran	23,293	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,876,238	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	1,866	2,098	\$ 99,219	\$ 47.29	1
2	Assistant Director of Nursing	1,946	2,165	77,224	35.67	2
3	Registered Nurses	17,972	20,104	620,682	30.87	3
4	Licensed Practical Nurses	39,771	43,767	1,107,404	25.30	4
5	CNAs & Orderlies	88,486	98,916	960,799	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,918	14,553	207,853	14.28	8
9	Activity Director	1,613	2,093	27,982	13.37	9
10	Activity Assistants	14,164	15,860	149,435	9.42	10
11	Social Service Workers	6,989	8,055	182,063	22.60	11
12	Dietician	1,838	2,049	23,627	11.53	12
13	Food Service Supervisor	1,886	2,104	47,995	22.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,753	6,656	75,198	11.30	15
16	Dishwashers	15,022	16,764	161,423	9.63	16
17	Maintenance Workers	6,265	6,822	117,872	17.28	17
18	Housekeepers	22,418	25,198	238,785	9.48	18
19	Laundry	8,567	9,923	97,251	9.80	19
20	Administrator	1,999	2,114	101,610	48.07	20
21	Assistant Administrator	1,967	2,177	56,053	25.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,542	9,466	181,562	19.18	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	2,985	3,568	55,233	15.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,933	2,175	34,848	16.02	33
34	TOTAL (lines 1 - 33)	264,900	296,627	\$ 4,624,118 *	\$ 15.59	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	356	\$ 15,185	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,785	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		1,362		48
49	TOTAL (lines 35 - 48)	356	\$ 61,332		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? Yes
If YES, give association name and amount. ICLTC \$12,802

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

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

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,909 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 284,797
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. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14

d. Have vehicle usage logs been maintained? 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT