

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Nrsg & Reh Ctr

Address: 345 Dixie Highway Chicago Heights 60411
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: 12/1/2002

Type of Ownership:

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

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

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
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 01/01/16 to 12/31/16 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) *
* Subject to the attached Accountants Consulting Report (Date)
(Print Name and Title)
(Firm Name Marcum, LLP
& Address) 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number

Prairie Manor Nrsg & Reh Ctr

#

0046011

Report Period Beginning:

01/01/16

Ending:

12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,168	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	148	TOTALS	148	54,168	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	30,431	4,828	11,826	47,085	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,431	4,828	11,826	47,085	14

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

86.92%

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?

YESNOX

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

YESNOX

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

Date started12/01/2002

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

YESXDate12/01/2002NONO

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

YESXNONOIf YES, enter number of beds certified148and days of care provided9,753

Medicare IntermediaryNational Government Services

IV. ACCOUNTING BASIS

ACCRUALXMODIFIEDCASH* CASH*

Is your fiscal year identical to your tax year?

YESXNONO

Tax Year:12/31/16Fiscal Year:12/31/16

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	314,959	45,219	17,482	377,660		377,660	9,444	387,104			1
2	Food Purchase		291,664		291,664		291,664	88	291,752			2
3	Housekeeping	271,421	65,140		336,561		336,561	1,088	337,649			3
4	Laundry	69,047	23,979		93,026		93,026		93,026			4
5	Heat and Other Utilities			192,685	192,685		192,685	1,506	194,191			5
6	Maintenance	134,000		255,880	389,880		389,880	8,952	398,832			6
7	Other (specify):*							5,420	5,420			7
8	TOTAL General Services	789,427	426,002	466,047	1,681,476		1,681,476	26,498	1,707,974			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	3,357,231	307,950	236,800	3,901,981		3,901,981	36,350	3,938,331			10
10a	Therapy	319,677			319,677		319,677		319,677			10a
11	Activities	224,666	39,605		264,271		264,271		264,271			11
12	Social Services	238,914			238,914		238,914	22,437	261,351			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,425	8,425			15
16	TOTAL Health Care and Programs	4,140,488	347,555	271,300	4,759,343		4,759,343	67,212	4,826,555			16
	C. General Administration											
17	Administrative	157,267			157,267		157,267	94,244	251,511			17
18	Directors Fees											18
19	Professional Services			740,576	740,576	(973)	739,603	(559,547)	180,056			19
20	Dues, Fees, Subscriptions & Promotions			93,127	93,127		93,127	(40,033)	53,094			20
21	Clerical & General Office Expenses	229,811	56,858	490,395	777,064		777,064	(341,743)	435,321			21
22	Employee Benefits & Payroll Taxes			963,678	963,678		963,678	(5,416)	958,262			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,779	8,779		8,779	850	9,629			24
25	Other Admin. Staff Transportation			1,285	1,285		1,285	991	2,276			25
26	Insurance-Prop.Liab.Malpractice			195,118	195,118		195,118	2,302	197,420			26
27	Other (specify):*							33,601	33,601			27
28	TOTAL General Administration	387,078	56,858	2,492,958	2,936,894	(973)	2,935,921	(814,752)	2,121,169			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,316,993	830,415	3,230,305	9,377,713	(973)	9,376,740	(721,041)	8,655,699			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			122,383	122,383		122,383	159,349	281,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			718	718		718	220,546	221,264			32
33	Real Estate Taxes			662,185	662,185	973	663,158	4,430	667,588			33
34	Rent-Facility & Grounds			492,000	492,000		492,000	(492,000)				34
35	Rent-Equipment & Vehicles			2,298	2,298		2,298	936	3,234			35
36	Other (specify):*			596	596		596	(596)				36
37	TOTAL Ownership			1,280,180	1,280,180	973	1,281,153	(107,335)	1,173,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		470,016	1,313,670	1,783,686		1,783,686	(27,668)	1,756,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,712	296,712		296,712		296,712			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		470,016	1,610,382	2,080,398		2,080,398	(27,668)	2,052,730			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,316,993	1,300,431	6,120,867	12,738,291		12,738,291	(856,044)	11,882,247			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	(78,681)	30		9
10	Interest and Other Investment Income	(70,396)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(444,979)	21		24
25	Fund Raising, Advertising and Promotional	(36,537)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(94,396)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (725,283)		\$	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)	(130,762)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (130,762)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (856,045)		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:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Other Income	\$ (11,124)	21	1
2	Jury Duty	(25)	10	2
3	Theft Loss	(1,058)	21	3
4	Collection Expense	(7,678)	21	4
5	Amortization	(596)	36	5
6	PAC Dues	(5,491)	20	6
7	Building Company - Management Fees	(7,300)	21	7
8	Building Company - Filing Fee	(250)	21	8
9	Building Company - Amortization Expense	(5,034)	31	9
10	Building Company - Legal Fees	(3,713)	19	10
11	Building Company - Professional Fees	(1,000)	19	11
12	Non-Allowable Legal Fees	(48,393)	19	12
13	Capitalized R&M	(2,734)	06	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	(94,396)		49

ID#0046011

Report Period Beginning:01/01/16

Ending:12/31/16

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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			178		9,266							9,444	1
2	Food Purchase	(294)		382									88	2
3	Housekeeping			982		106							1,088	3
4	Laundry													4
5	Heat and Other Utilities			1,370		136							1,506	5
6	Maintenance	(2,734)		2,862	8,574	250							8,952	6
7	Other (specify):*				4,140	1,280							5,420	7
8	TOTAL General Services	(3,028)		5,774	12,714	11,038							26,498	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25)				38,550	(774)		(1,400)				36,350	10
10a	Therapy													10a
11	Activities													11
12	Social Services					22,437							22,437	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,425							8,425	15
16	TOTAL Health Care and Programs	(25)				69,412	(774)		(1,400)				67,212	16
	C. General Administration													
17	Administrative			2,864	16,306	75,074							94,244	17
18	Directors Fees													18
19	Professional Services	(53,105)	4,713	(382,457)		(128,698)							(559,547)	19
20	Fees, Subscriptions & Promotions	(42,028)		930		1,065							(40,033)	20
21	Clerical & General Office Expenses	(472,389)	7,550	5,771	98,812	18,513							(341,743)	21
22	Employee Benefits & Payroll Taxes				(5,416)								(5,416)	22
23	Inservice Training & Education													23
24	Travel and Seminar			146		704							850	24
25	Other Admin. Staff Transportation			991									991	25
26	Insurance-Prop.Liab.Malpractice			1,715		587							2,302	26
27	Other (specify):*				21,055	12,546							33,601	27
28	TOTAL General Administration	(567,523)	12,263	(370,040)	130,757	(20,209)							(814,752)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(570,576)	12,263	(364,266)	143,471	60,241	(774)		(1,400)				(721,041)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(78,681)	235,055	2,286		689							159,349	30
31	Amortization of Pre-Op. & Org.	(5,034)	5,034											31
32	Interest	(70,396)	282,445	8,299		198							220,546	32
33	Real Estate Taxes			3,998		432							4,430	33
34	Rent-Facility & Grounds		(492,000)										(492,000)	34
35	Rent-Equipment & Vehicles			936									936	35
36	Other (specify):*	(596)											(596)	36
37	TOTAL Ownership	(154,707)	30,534	15,519		1,319							(107,335)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(27,668)						(27,668)	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						(27,668)						(27,668)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(725,283)	42,797	(348,747)	143,471	61,560	(28,442)		(1,400)				(856,044)	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	\$ 492,000	Prairie Manor Property, LLC	100.00%	\$	\$ (492,000)	1
2	V	32	Interest Income	246	Prairie Manor Property, LLC	100.00%		(246)	2
3	V	21	Management Fees		Prairie Manor Property, LLC	100.00%	7,300	7,300	3
4	V	19	Legal Expenses		Prairie Manor Property, LLC	100.00%	3,713	3,713	4
5	V	19	Professional Fees		Prairie Manor Property, LLC	100.00%	1,000	1,000	5
6	V	21	Filing Fee		Prairie Manor Property, LLC	100.00%	250	250	6
7	V	30	Depreciation Expense		Prairie Manor Property, LLC	100.00%	235,055	235,055	7
8	V	31	Amortization Expense		Prairie Manor Property, LLC	100.00%	5,034	5,034	8
9	V	32	Interest Expense - Providence		Prairie Manor Property, LLC	100.00%	282,691	282,691	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 492,246			\$ 535,043	\$ * 42,797	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 178	\$ 178	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	382	382	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	982	982	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,370	1,370	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,862	2,862	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,864	2,864	20
21	V	19	Professional Fees	388,176	Extended Care Consulting, LLC	100.00%	5,719	(382,457)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	930	930	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,771	5,771	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	146	146	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	991	991	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,715	1,715	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,286	2,286	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,299	8,299	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,998	3,998	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	936	936	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			\$ 388,176			\$ 39,429	\$ * (348,747)	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 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%	8,574	\$	8,574
16	V	06	Maintenance (Direct)	18,054	Extended Care Consulting, LLC	100.00%	18,054		
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	804		804
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,336		3,336
19	V								
20	V								
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,306		16,306
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	98,812		98,812
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,055		21,055
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			
26	V	22	Employee Benefits	5,416	Extended Care Consulting, LLC	100.00%			(5,416)
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 23,470			\$ 166,941	\$ *	143,471

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

VII. RELATED PARTIES (continued)

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

☒ X

 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%	\$ 106	\$ 106	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	136	136	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	250	250	17
18	V	19	Professional Fees	129,396	Extended Care Clinical, LLC	100.00%	698	(128,698)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,065	1,065	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,770	2,770	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	704	704	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	587	587	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	689	689	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	198	198	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	432	432	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,266	9,266	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,280	1,280	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	38,550	38,550	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	22,437	22,437	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,425	8,425	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	75,074	75,074	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	15,743	15,743	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,546	12,546	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 129,396			\$ 190,956	\$ * 61,560	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 10,753	MAC Rx, LLC	100.00%	\$ 9,978	\$ (774)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	384,166	MAC Rx, LLC	100.00%	356,498	(27,668)	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			\$ 394,918			\$ 366,476	\$ * (28,442)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 203,441	\$ 203,441	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	203,441	CCS Employee Benefits Group	100.00%		(203,441)	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			\$ 203,441			\$ 203,441	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	24,050	Vent Lease LLC	100.00%	22,650	\$ (1,400)	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			\$ 24,050			\$ 22,650	\$ * (1,400)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUM. TRUST	11.11 %	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		Prairie Manor Property, LLC		BUILDING COMPANY	1
2	DANIEL ROTHNER ACCUM. TRUST	11.11 %	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	KATHRYN VALES ACCUM. TRUST	11.11 %	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	KIMBERLY RICHMAN ACCUM. TRUST	11.11 %	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	MELISSA ROTHNER ACCUM. TRUST	11.11 %	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	NATHAN & SHIRLEY ROTHNER TRUST	22.22 %	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM. TRUST	11.11 %	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	WILLIAM ROTHNER ACCUM. TRUST	11.11 %	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								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	Mark Steinberg	Relative	Administrative		See Attached	2.72	4.94%	Alloc Sal&Fee	\$ 9,845	17-7	1
2	Adam Vales	Relative	Clerical		See Attached	1.03	2.58%	Alloc Sal	1,896	22-7	2
3	Kimberly Rudolph	Relative	Clerical		See Attached	0.26	3.41%	Alloc Sal	80	21-7	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	\$ 11,821		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 Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	01	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$	47,085	\$ 178	1
2	02	Food	Patient Days	1,380,761	34	11,203		47,085	382	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		47,085	982	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		47,085	1,370	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		47,085	2,862	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		47,085	2,864	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		47,085	5,719	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		47,085	930	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		47,085	5,771	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		47,085	146	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		47,085	991	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		47,085	1,715	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		47,085	2,286	13
14	32	Interest	Patient Days	1,380,761	34	243,379		47,085	8,299	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		47,085	3,998	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		47,085	936	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,218	\$		\$ 39,429	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	47,085	8,574	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		18,054	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		47,085	804	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			3,336	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	47,085	16,306	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	47,085	98,812	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		47,085	21,055	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,222,483	\$ 4,461,323		\$ 166,941	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 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	03	Housekeeping	Patient Days	818,091	19	\$ 1,844	\$	47,085	\$ 106	1
2	05	Utilities	Patient Days	818,091	19	2,355		47,085	136	2
3	06	Maintenance	Patient Days	818,091	19	4,352		47,085	250	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		47,085	698	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		47,085	1,065	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		47,085	2,770	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		47,085	704	7
8	26	Insurance	Patient Days	818,091	19	10,196		47,085	587	8
9	30	Depreciation	Patient Days	818,091	19	11,978		47,085	689	9
10	32	Interest	Patient Days	818,091	19	3,446		47,085	198	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		47,085	432	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	47,085	9,266	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		47,085	1,280	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	47,085	38,550	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	47,085	22,437	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		47,085	8,425	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	47,085	75,074	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	47,085	15,743	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		47,085	12,546	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,317,844	\$ 2,798,561		\$ 190,956	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 MAC Rx, LLC
Street Address 2307 S. Mount Prospect Road
City / State / Zip Code Des Plaines, IL 60018
Phone Number (224)220-2700
Fax Number (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 9,978	1
	2	21	Clerical & General Office Expense	Direct Allocation						2
	3	22	Employee Benefits	Direct Allocation						3
	4	39	Ancillary	Direct Allocation					356,498	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				\$	\$		\$ 366,476	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		\$	\$		\$ 203,441	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				\$	\$		\$ 203,441	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	10	Various Equipment	Direct Allocation					22,650	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				\$	\$		\$ 22,650	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Providence Bank		X	Mortgage			\$	6,083,269			\$	282,691	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6													6
7													7
8					-								8
9	TOTAL Facility Related						\$	6,083,269			\$	282,691	9
	B. Non-Facility Related*												
10	Interest Income		X								(70,396)	10	
11	Interest		X								718	11	
12	Interest Income - Bldg. Co		X								(244)	12	
13	See Supplemental Schedule				-						8,497	13	
14	TOTAL Non-Facility Related						\$				\$	(61,425)	14
15	TOTALS (line 9+line14)						\$	6,083,269			\$	221,266	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.)

** 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	Allocated - EC Consulting	X					\$					\$	8,299	15
16	Allocated - EC Clinical	X											198	16
17														17
18														18
19														19
20	TOTAL Non-Facility Related												8,497	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.) 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.)

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Prairie Manor Nrsg & Reh Ctr

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0046011

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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. <u>32-17-131-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>638,429.99</u>	\$ <u>638,429.99</u>
2. <u>See Attached</u>	<u>Allocated from Extended Care Consul</u>	\$ <u>167,518.13</u>	\$ <u>3,997.75</u>
3. <u>See Attached</u>	<u>Allocated from Extended Care Clinica</u>	\$ <u>167,518.13</u>	\$ <u>432.02</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>973,466.25</u>	\$ <u>642,859.76</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

FACILITY NAME	<u>Prairie Manor Nrsng & Reh Ctr</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0046011</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

Enter the tax index number and real estate tax assessed for 2015 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 2015.

Page 10B

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2002	\$ 459,864	1
2	Allocated from 2201 W. Main, LLC / Clinical			21,684	2
3	TOTALS			\$ 481,548	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	148			1988	\$ 4,650,000	\$ 235,055	39	\$ 119,231	\$ (115,824)	\$ 1,660,279	4	
5				2013	1,609,158		39	41,260	41,260	165,040	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			2003	33,716		20	1,524	1,524	23,450	9	
10	Various			2004	215,253		20	9,744	9,744	149,063	10	
11	Various			2005	96,470		20	2,221	2,221	77,789	11	
12	Various			2006	90,263		20	4,360	4,360	49,165	12	
13	Various			2007	56,209		20	2,810	2,810	27,638	13	
14	Various			2008	31,219		20	1,871	1,871	16,028	14	
15	Various			2009	43,314		20	1,608	1,608	23,185	15	
16	Various			2010	44,836		20	2,242	2,242	13,967	16	
17	Various			2011	104,287		20	5,296	5,296	31,642	17	
18	Various			2012	71,505		20	3,575	3,575	17,087	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	

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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)	102,941	1,433		1,433		69,362	68
69	Financial Statement Depreciation		122,383			(122,383)		69
70	TOTAL (lines 4 thru 69)	\$ 7,149,172	\$ 358,871		\$ 197,175	\$ (161,696)	\$ 2,323,696	70

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr

0046011

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Totals from Page 12A, Carried Forward		\$ 7,149,172	\$ 358,871		\$ 197,175	\$ (161,696)	\$ 2,323,696	1
2	Boiler Modifications	2013	17,584		20	879	879	3,444	2
3	Sewer Repair	2013	2,555		20	128	128	500	3
4	Furnish & Install New Buffer Channel & Spring In Elevator	2013	37,400		20	1,870	1,870	6,701	4
5	Installed 2 New 200 Ampere Three Phase Three Wire 208 Volt Feeder	2013	6,625		20	331	331	1,187	5
6	Installed Hot Water Coil & Pump Assembly	2014	15,382		20	769	769	2,307	6
7	Repair Heating System, Valve, Panel Gauge, Thermostats, Transm	2014	4,215		20	211	211	615	7
8	Furnish & Install 4 Door Restrictors	2014	5,960		20	298	298	869	8
9	Replaced Cracked Coils On Air Unit	2014	41,310		20	2,066	2,066	6,024	9
10	Remove & Install 2 Mixing Valves	2014	4,439		20	222	222	647	10
11	Emergency Coil Repairs	2014	13,690		20	685	685	1,882	11
12	Furnish & Install 2 Faux Stucco Signs	2014	17,328		20	1,155	1,155	2,792	12
13	Replace Actuator For Outside Air Damper For Air Handler	2014	9,149		20	457	457	953	13
14	Installed New Valves On Boiler	2014	3,933		20	197	197	557	14
15	Millwork, Patch Walls, Repair Floor, Updated Plumbing & Electr	2014	28,800		20	1,440	1,440	4,200	15
16	Excavated & Repaired Leak On Auxiliary Valve On Fire Hydrant	2014	3,250		20	163	163	420	16
17	Reception/Meeting Room- Ceilings, Wood Trim, Doors, Tile, Plum	2014	188,530		20	9,427	9,427	23,566	17
18	New Awnings	2015	6,100		20	305	305	585	18
19	Replaced 28Ft Of Pipes	2015	15,663		20	783	783	1,436	19
20	Generator Installation	2015	119,422		20	5,971	5,971	7,464	20
21	8 Wood Doors	2015	4,967		20	248	248	352	21
22	Walk-In Freezer Doors	2015	7,346		20	367	367	490	22
23	Flood Light And Fixtures	2015	4,600		20	230	230	326	23
24	Ice/Water Shield, Standing Seam Roof & Metal Gutters And Dow	2015	15,653		20	783	783	1,565	24
25	4 Doors And Frames	2015	34,250		20	1,713	1,713	3,425	25
26	Installation Of Generator	2015	58,500		20	2,925	2,925	5,119	26
27	Replace Leaking Domestic Booster Pump On Hot Water Boiler	2015	2,761		20	138	138	230	27
28	Convection Base Heater	2016	7,485		20	281	281	281	28
29	Electrical Work (New Feed)	2016	14,877		20	186	186	186	29
30	Replaced Faulty Pneumatic Controls. All New Pneumatic Controls	2016	2,734		20	137	137	137	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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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)		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 7,843,679	\$ 358,871		\$ 231,538	\$ (127,333)	\$ 2,401,955	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr

0046011

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, LLC	2002	2,914	75	39	75		1,068	3
4	Allocated from Extended Care Consulting, LLC	2016	8,184	181	39	181		1,722	4
5	Allocated from 2201 W. Main, LLC	2002	26,967	691	39	691		9,882	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	157	8	20	8		78	9
10	Allocated from Extended Care Consulting, LLC	2009	94	5	20	5		38	10
11	Allocated from Extended Care Consulting, LLC	2010	920	46	20	46		322	11
12	Allocated from Extended Care Consulting, LLC	2011	331	17	20	17		99	12
13	Allocated from Extended Care Consulting, LLC	2012	109	5	20	5		27	13
14	Allocated from Extended Care Consulting, LLC	2014	1,512	76	20	76		227	14
15	Allocated from Extended Care Consulting, LLC	2016	1,813	91	20	91		91	15
16									16
17	Allocated from 2201 W. Main, LLC	2002	22,277		20			22,277	17
18	Allocated from 2201 W. Main, LLC	2003	26,253		20			26,253	18
19	Allocated from 2201 W. Main, LLC	2005	1,304	2	20	2		1,304	19
20	Allocated from 2201 W. Main, LLC	2009	235	12	20	12		94	20
21	Allocated from 2201 W. Main, LLC	2014	2,189	109	20	109		328	21
22	Allocated from 2201 W. Main, LLC	2015	371	19	20	19		37	22
23	Allocated from 2201 W. Main, LLC	2016	1,466	73	20	73		73	23
24									24
25	Allocated from Extended Care Clinical, LLC	2002	2,407		20			2,407	25
26	Allocated from Extended Care Clinical, LLC	2003	2,837		20			2,837	26
27	Allocated from Extended Care Clinical, LLC	2005	141		20			141	27
28	Allocated from Extended Care Clinical, LLC	2009	25	1	20	1		10	28
29	Allocated from Extended Care Clinical, LLC	2014	237	12	20	12		35	29
30	Allocated from Extended Care Clinical, LLC	2015	40	2	20	2		4	30
31	Allocated from Extended Care Clinical, LLC	2016	158	8	20	8		8	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 102,941	\$ 1,433		\$ 1,433	\$	\$ 69,362	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 102,941	\$ 1,433		\$ 1,433	\$	\$ 69,362	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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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)		\$ 102,941	\$ 1,433		\$ 1,433	\$	\$ 69,362	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 270,378	\$ 777	\$ 49,429	\$ 48,652	10	\$ 152,174	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,584,603				10	384,603	73
74								74
75	TOTALS	\$ 1,854,982	\$ 777	\$ 49,429	\$ 48,652		\$ 536,777	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 Clinical, LLC	2012	\$ 2,957	\$ 591	\$ 591	\$	5	\$ 2,648	76
77		Allocated from EC Consulting, L	2015	6,154	174	174		5	5,806	77
78										78
79										79
80	TOTALS			\$ 9,111	\$ 765	\$ 765	\$		\$ 8,454	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)	\$ 10,189,320	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 360,413	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 281,732	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (78,681)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,947,186	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

X

NO
- If NO, see instructions.

		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?

YESNO
16. Rental Amount for movable equipment: \$ 2,298 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	Allocated - Extended Care Consulting		\$	\$ 936	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 936	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$ 597,738	\$		\$ 597,738	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				82,180			82,180	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				633,752			633,752	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				383,477			383,477	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						86,539			86,539	13
14	TOTAL			\$			\$ 1,313,670	\$ 470,016		\$ 1,783,686	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,264	\$ 81,703	1
2	Cash-Patient Deposits	23,130	23,130	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,843,856	1,843,856	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	465,046	465,046	6
7	Other Prepaid Expenses	4,448	4,448	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	3,554,942	3,732,480	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,894,686	\$ 6,150,663	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		459,864	13
14	Buildings, at Historical Cost		6,350,541	14
15	Leasehold Improvements, at Historical Cost	1,256,751	1,356,751	15
16	Equipment, at Historical Cost	527,203	1,727,203	16
17	Accumulated Depreciation (book methods)	(1,154,126)	(4,974,013)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,470	43,999	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 632,298	\$ 4,964,345	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,526,984	\$ 11,115,008	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,551,668	\$ 2,551,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,516	20,516	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,056	240,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,503	10,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)	670,351	670,351	32
33	Accrued Interest Payable		23,577	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,493,094	\$ 3,516,671	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,083,269	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,083,269	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,493,094	\$ 9,599,940	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,033,890	\$ 1,515,068	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,526,984	\$ 11,115,008	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,442,226	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,442,227	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	591,663	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 591,663	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,033,890	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,276,906	1
2	Discounts and Allowances for all Levels	(5,717,805)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,559,101	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,250,062	6
7	Oxygen	368	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,250,430	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	2,353	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378,399	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,876	19
20	Radiology and X-Ray	15,403	20
21	Other Medical Services	1,847	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 438,878	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	70,396	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 70,396	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,149	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,149	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,329,954	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,681,476	31
32	Health Care	4,759,343	32
33	General Administration	2,936,894	33
	B. Capital Expense		
34	Ownership	1,280,180	34
	C. Ancillary Expense		
35	Special Cost Centers	1,783,686	35
36	Provider Participation Fee	296,712	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,738,291	40
41	Income before Income Taxes (line 30 minus line 40)**	591,663	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 591,663	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,549,003	44
45	Private Pay - Net Inpatient Revenue	960,369	45
46	Medicare - Net Inpatient Revenue	581,461	46
47	Other-(specify) Hospice	312,143	47
48	Other-(specify) Insurance	156,125	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,559,101	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	1,350	1,630	\$ 72,897	\$ 44.72	1
2	Assistant Director of Nursing	1,270	1,518	52,892	34.85	2
3	Registered Nurses	17,142	18,909	670,936	35.48	3
4	Licensed Practical Nurses	51,606	55,614	1,585,910	28.52	4
5	CNAs & Orderlies	69,735	76,843	877,310	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,282	16,394	319,677	19.50	8
9	Activity Director	3,921	4,399	55,053	12.51	9
10	Activity Assistants	16,960	18,705	169,613	9.07	10
11	Social Service Workers	8,359	9,108	238,914	26.23	11
12	Dietician					12
13	Food Service Supervisor	3,803	4,238	91,589	21.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,767	6,713	73,115	10.89	15
16	Dishwashers	14,826	16,643	150,255	9.03	16
17	Maintenance Workers	5,903	6,509	134,000	20.59	17
18	Housekeepers	24,482	27,669	271,421	9.81	18
19	Laundry	6,871	7,557	69,047	9.14	19
20	Administrator	2,010	2,171	113,628	52.34	20
21	Assistant Administrator	1,401	1,702	43,639	25.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,548	13,087	229,811	17.56	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	3,160	3,699	62,419	16.87	31
32	Other Health Care(specify)					32
33	Other(specify)	1,916	2,206	34,867	15.81	33
34	TOTAL (lines 1 - 33)	266,313	295,313	\$ 5,316,993 *	\$ 18.00	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	334	\$ 17,482	01-03	35
36	Medical Director	Monthly	34,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,858	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					48
49	TOTAL (lines 35 - 48)	334	\$ 54,840		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	28	\$ 1,380	10-03	50
51	Licensed Practical Nurses	23	969	10-03	51
52	Certified Nurse Assistants/Aides	8,537	231,593	10-03	52
53	TOTAL (lines 50 - 52)	8,588	\$ 233,942		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
XIX. SUPPORT SCHEDULES

Prairie Manor Nrsg & Reh Ctr

0046011

Report Period Beginning: 01/01/16

Page 21
Ending: 12/31/16

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Mary Stucker		Administrator	0	\$ 113,627	Workers' Compensation Insurance		\$ 233,729	IDPH License Fee		\$ 1,992		
Mary Boulos		Asst. Administrator	0	43,638	Unemployment Compensation Insurance		56,352	Advertising: Employee Recruitment		20,211		
					FICA Taxes		399,849	Health Care Worker Background Check				
					Employee Health Insurance		222,935	(Indicate # of checks performed 565)		7,132		
					Employee Meals			Patient Background Checks				
					Illinois Municipal Retirement Fund (IMRF)*			Licenses and Permits		463		
					Employee Physicals		625	Dues and Subscriptions		21,302		
					Pension Expense		36,275	Allocated - Ext. Care Consulting		930		
					Other Employee Welfare		8,183	Allocated - Ext Care Clinical		1,065		
					Holiday Expense		314					
								Less: Public Relations Expense		()		
								Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 157,266	TOTAL (agree to Schedule V, line 22, col.8)		\$ 958,262	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 53,095		
(List each licensed administrator separately.)												
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount		Description	Line #	Amount	Description		Amount		
			\$				\$	Out-of-State Travel		\$		
								In-State Travel				
								Seminar Expense		8,779		
								Allocated - Ext. Care Consulting		146		
								Allocated - Ext. Care Clinical		704		
								Entertainment Expense		()		
								(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3)			\$		TOTAL		\$	TOTAL		\$ 9,629		
(Attach a copy of any management service agreement)												
C. Professional Services												
Vendor/Payee		Type	Amount									
Paycor Payroll Services		Data Processing/Payroll	\$ 30,127									
ECC-EHealth Data Solutions		MDS Software Fee	1,590									
ECC- Reimb Achieve		Data Processing	17,535									
ECC- Ability Network Inc		Medicare Billing	4,640									
Matrixcare		Data Processing	310									
National Datacare Corporation		Resident Fund Processing	1,161									
ECC Consulting		Home Office Expenses	388,176									
ECC Clinical		Home Office Expenses	129,396									
Marcum		Accounting Fees	24,476									
See Attached		Legal Fees	121,416									
See Supplemental Schedule			21,749									
TOTAL (agree to Schedule V, line 19, column 3)			\$ 740,575									
(For legal fee disclosure, see page 39 of instructions)												

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

XX. GENERAL INFORMATION:

- | | | |
|------|---|---|
| (1) | Are nursing employees (RN,LPN,NA) represented by a union? | <u>No</u> |
| (2) | Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. | <u>Yes</u>
<u>ILCLTC \$16,640.20</u> |
| (3) | Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report? | <u>Yes</u>
<u>Yes</u> |
| (4) | Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity? | <u>No</u>
<u>N/A</u> |
| (5) | Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? | <u>Yes</u>
<u>10 Years</u> |
| (6) | Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. | \$ <u>86,024</u> Line <u>10</u> |
| (7) | Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation. | <u>Yes</u> |
| (8) | Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. | <u>No</u>
<u>N/A</u> |
| (9) | Are you presently operating under a sublease agreement? | YES <u>X</u> NO |
| (10) | Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. | <u>N/A</u> |
| (11) | Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V. | \$ <u>296,712</u> |
| (12) | Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation. | <u>No</u> |