

		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: <u>0042671</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Prairie Village Hlthcare Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1024 West Walnut</u> <u>Jacksonville</u> <u>62650</u>																									
Number City Zip Code																									
County: <u>Morgan</u>																									
Telephone Number: <u>(217) 245 - 5175</u> Fax # <u>(217) 243 - 4276</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>05/01/97</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie Village Hlthcare Ctr

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

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,503</u>	<u>1,279</u>	<u>3,525</u>	<u>17,307</u>	8
9	SNF/PED					9
10	ICF	<u>8,786</u>	<u>899</u>	<u>385</u>	<u>10,070</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,289</u>	<u>2,178</u>	<u>3,910</u>	<u>27,377</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.37%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
0 (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)
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 53 and days of care provided 2,411

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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	155,631	22,231	9,804	187,666		187,666	103	187,769			1
2	Food Purchase		183,759		183,759		183,759	(1,703)	182,056			2
3	Housekeeping	95,172	17,312		112,484		112,484	571	113,055			3
4	Laundry	40,815	15,076		55,891		55,891		55,891			4
5	Heat and Other Utilities			102,967	102,967		102,967	796	103,763			5
6	Maintenance	77,433	260	100,951	178,644		178,644	6,649	185,293			6
7	Other (specify):* See Supplemental	17,500		1,932	19,432		19,432	467	19,899			7
8	TOTAL General Services	386,551	238,638	215,654	840,843		840,843	6,883	847,726			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,262,883	118,231	2,951	1,384,065		1,384,065		1,384,065			10
10a	Therapy	59,377			59,377		59,377		59,377			10a
11	Activities	35,195	10,392	1,089	46,676		46,676		46,676			11
12	Social Services	43,947		19,419	63,366		63,366		63,366			12
13	CNA Training											13
14	Program Transportation	811		229	1,040		1,040		1,040			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	1,402,213	128,623	41,688	1,572,524		1,572,524		1,572,524			16
	C. General Administration											
17	Administrative	134,614			134,614		134,614	11,147	145,761			17
18	Directors Fees											18
19	Professional Services			231,361	231,361		231,361	(160,297)	71,064			19
20	Dues, Fees, Subscriptions & Promotions			35,976	35,976		35,976	(8,939)	27,037			20
21	Clerical & General Office Expenses	105,424	6,629	307,082	419,135		419,135	(220,905)	198,230			21
22	Employee Benefits & Payroll Taxes			324,599	324,599		324,599	(3,936)	320,663			22
23	Inservice Training & Education			4,234	4,234		4,234		4,234			23
24	Travel and Seminar			1,042	1,042		1,042	85	1,127			24
25	Other Admin. Staff Transportation			27,842	27,842		27,842	576	28,418			25
26	Insurance-Prop.Liab.Malpractice			126,027	126,027		126,027	9,737	135,764			26
27	Other (specify):* See Supplemental							13,399	13,399			27
28	TOTAL General Administration	240,038	6,629	1,058,163	1,304,830		1,304,830	(359,133)	945,697			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,028,802	373,890	1,315,505	3,718,197		3,718,197	(352,250)	3,365,947			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
Security		17,500				1,932		19,432
								-
Alloc - Extended Care Consulting, LLC								-
Gen. Services - Employee Benefits						467		467
								-
								-
								-
Sub-Total		17,500		-		2,399		19,899
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 27 - Other General Administration								
Alloc - Extended Care Consulting, LLC								-
Gen. Admin. - Employee Benefits						13,399		13,399
								-
								-
								-
								-
								-
Sub-Total		-		-		13,399		13,399

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
American Express	Business Matters	Various	Various	4,919			4,919
Angela Carver	Business Matters	Various	Various	150			150
Brandy Lomelino	Business Matters	Various	Various	708			708
Care Management Facility	Business Matters	Various	Various	4,886			4,886
Countryside Nursing & Rehab	Business Matters	Various	Various	809			809
Gail Silva	Business Matters	Various	Various	234			234
Jerri Springer	Business Matters	Various	Various	90			90
Kelly Hall	Business Matters	Various	Various	6,447			6,447
Laura Sepessy	Business Matters	Various	Various	1,328			1,328
Lea Jolley-Kaufmann	Business Matters	Various	Various	1,927			1,927
Patricia Bedwell	Business Matters	Various	Various	6,278			6,278
Jerri Springer	Business Matters	Various	Various	64			64
							-
Alloc - Extended Care Consulting, LLC				576			576
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				28,418	-	-	28,418

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			12,903	12,903		12,903	86,613	99,516			30
31	Amortization of Pre-Op. & Org.			515	515		515		515			31
32	Interest			30,370	30,370		30,370	76,550	106,920			32
33	Real Estate Taxes							27,816	27,816			33
34	Rent-Facility & Grounds			273,900	273,900		273,900	(273,900)				34
35	Rent-Equipment & Vehicles			25,822	25,822		25,822	544	26,366			35
36	Other (specify):* See Supplemental							8,905	8,905			36
37	TOTAL Ownership			343,510	343,510		343,510	(73,472)	270,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,930	699,224	855,154		855,154		855,154			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,477	222,477		222,477		222,477			42
43	Other (specify):* See Supplemental	163,329			163,329		163,329	(163,329)				43
44	TOTAL Special Cost Centers	163,329	155,930	921,701	1,240,960		1,240,960	(163,329)	1,077,631			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,192,131	529,820	2,580,716	5,302,667		5,302,667	(589,051)	4,713,616			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 36 - Other Capital Costs								
Prairie Village Healthcare Center, LLC								-
Mortgage Insurance Premiums				8,905		8,905		
						-		
						-		
						-		
						-		
Sub-Total		-		-		8,905		8,905
Line 43 - Other Special Cost Centers								
Non - Allowable		163,329						163,329
						-		
						-		
						-		
						-		
						-		
Sub-Total		163,329		-		-		163,329

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				9
10	Interest and Other Investment Income	(497)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,925)	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	(267,875)	21		24
25	Fund Raising, Advertising and Promotional	(9,480)	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 Supplemental Schedule	(238,848)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (518,625)		\$	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)	(70,426)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (70,426)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (589,051)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Collections	\$ (2,627)	19	1
2	Lobbying	(1,901)	19	2
3	Line of Credit Fees	(2,141)	19	3
4	Legal	(36,953)	19	4
5	Bank Charges	(13,226)	21	5
6	Theft Loss	(613)	21	6
7	Non-Allowable	(163,329)	43	7
8				8
9				9
10				10
11				11
12				12
13	Prairie Village Healthcare Centers, LLC			13
14	Professional Fees	(14,225)	19	14
15	Administrative Expense	(600)	21	15
16	Bank Charges	(439)	21	16
17	Amortization	(2,794)	31	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	(238,848)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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	0	0	103	0	0	0	0	0	0	0	0	103	1
2	Food Purchase	(1,925)	0	222	0	0	0	0	0	0	0	0	(1,703)	2
3	Housekeeping	0	0	571	0	0	0	0	0	0	0	0	571	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	796	0	0	0	0	0	0	0	0	796	5
6	Maintenance	0	0	1,664	4,985	0	0	0	0	0	0	0	6,649	6
7	Other (specify):*	0	0	0	467	0	0	0	0	0	0	0	467	7
8	TOTAL General Services	(1,925)	0	3,356	5,452	0	0	0	0	0	0	0	6,883	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	1,666	9,481	0	0	0	0	0	0	0	11,147	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(57,847)	14,225	(116,675)	0	0	0	0	0	0	0	0	(160,297)	19
20	Fees, Subscriptions & Promotions	(9,480)	0	541	0	0	0	0	0	0	0	0	(8,939)	20
21	Clerical & General Office Expenses	(282,753)	1,039	3,356	57,453	0	0	0	0	0	0	0	(220,905)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(3,936)	0	0	0	0	0	0	0	(3,936)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	85	0	0	0	0	0	0	0	0	85	24
25	Other Admin. Staff Transportation	0	0	576	0	0	0	0	0	0	0	0	576	25
26	Insurance-Prop.Liab.Malpractice	0	8,740	997	0	0	0	0	0	0	0	0	9,737	26
27	Other (specify):*	0	0	0	13,399	0	0	0	0	0	0	0	13,399	27
28	TOTAL General Administration	(350,080)	24,004	(109,454)	76,397	0	0	0	0	0	0	0	(359,133)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(352,005)	24,004	(106,098)	81,849	0	0	0	0	0	0	0	(352,250)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	85,284	1,329	0	0	0	0	0	0	0	0	86,613	30
31	Amortization of Pre-Op. & Org.	(2,794)	2,794	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(497)	72,221	4,826	0	0	0	0	0	0	0	0	76,550	32
33	Real Estate Taxes	0	25,492	2,324	0	0	0	0	0	0	0	0	27,816	33
34	Rent-Facility & Grounds	0	(273,900)	0	0	0	0	0	0	0	0	0	(273,900)	34
35	Rent-Equipment & Vehicles	0	0	544	0	0	0	0	0	0	0	0	544	35
36	Other (specify):*	0	8,905	0	0	0	0	0	0	0	0	0	8,905	36
37	TOTAL Ownership	(3,291)	(79,204)	9,023	0	0	0	0	0	0	0	0	(73,472)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(163,329)	0	0	0	0	0	0	0	0	0	0	(163,329)	43
44	TOTAL Special Cost Centers	(163,329)	0	0	0	0	0	0	0	0	0	0	(163,329)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(518,625)	(55,200)	(97,075)	81,849	0	0	0	0	0	0	0	(589,051)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 273,900	Prairie Village Healthcare Center, LLC	100.00%	\$	\$ (273,900)	1
2	V	32	Interest	243	Prairie Village Healthcare Center, LLC	100.00%		(243)	2
3	V	19	Professional Fees		Prairie Village Healthcare Center, LLC	100.00%	14,225	14,225	3
4	V	21	Office		Prairie Village Healthcare Center, LLC	100.00%	1,039	1,039	4
5	V	26	Property Insurance		Prairie Village Healthcare Center, LLC	100.00%	8,740	8,740	5
6	V	30	Depreciation		Prairie Village Healthcare Center, LLC	100.00%	85,284	85,284	6
7	V	31	Amortization		Prairie Village Healthcare Center, LLC	100.00%	2,794	2,794	7
8	V	32	Interest		Prairie Village Healthcare Center, LLC	100.00%	72,464	72,464	8
9	V	33	Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	25,492	25,492	9
10	V	36	Mortgage Insurance Premiums		Prairie Village Healthcare Center, LLC	100.00%	8,905	8,905	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 274,143			\$ 218,943	\$ * (55,200)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sherwin Ray	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	Prairie Village			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Healthcare CTR	Jacksonville, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

SEE ACCOUNTANTS' PREPARATION REPORT

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
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28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 4,985	\$ 4,985	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	467	467	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,481	9,481	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	57,453	57,453	20
21	V	21	Office and Clerical (Direct)	13,119	Extended Care Consulting, LLC	100.00%	13,119		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,242	12,242	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,157	1,157	23
24	V	22	Employee Benefits	3,936	Extended Care Consulting, LLC	100.00%		(3,936)	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			\$ 17,055			\$ 98,904	\$ * 81,849	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 103	\$ 103	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	222	222	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	571	571	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	796	796	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	1,664	1,664	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,666	1,666	20
21	V	19	Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	3,325	(116,675)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	541	541	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	3,356	3,356	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	85	85	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	576	576	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	997	997	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,329	1,329	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,826	4,826	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,324	2,324	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	544	544	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			\$ 120,000			\$ 22,925	\$ * (97,075)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	\$ 81,745	CCS VEBA	100.00%	\$ 81,745	\$	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			\$ 81,745			\$ 81,745	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Sherwin Ray	Shareholder	Administration	33.33%	See Supplemental	7.88	19.70%	Salary	\$ 45,008	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	0.42	1.04%	Alloc. Salary	762	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 45,770		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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation								
Sherwin Ray								
Prairie Village Healthcare Center	7.88	40.00	19.70%	228,468	-		45,008	-
Timber Point Healthcare Center	7.88	40.00	19.70%	228,468	-		45,008	-
Rushville Nursing & Rehab Center	7.00	40.00	17.50%	228,468	-		39,982	-
Countryside Nursing & Rehab Center	17.24	40.00	43.10%	228,468	-		98,470	-
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Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation								
Adam Vales								
Prairie Village Healthcare Center	0.42	40.00	1.04%	73,410	-		762	-
Timber Point Healthcare Center	0.85	40.00	2.12%	73,410	-		1,556	-
Rushville Nursing & Rehab Center	0.51	40.00	1.27%	73,410	-		935	-
Countryside Nursing & Rehab Center	1.29	40.00	3.21%	73,410	-		2,360	-
Kensington Nursing & Rehab Center	0.86	40.00	2.14%	73,410	-		1,572	-
Park House Nursing & Rehab Center	0.63	40.00	1.57%	73,410	-		1,151	-
Other Insured Entities	35.46	40.00	88.65%	73,410	-		65,075	-
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Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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 Prairie Village Healthcare Center, LLC
Street Address 1024 West Walnut
City / State / Zip Code Jacksonville, Illinois 62650
Phone Number (217) 245 - 5175
Fax Number (217) 243 - 4276

	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$	27,377	\$ 103	1
2	2	Food	Patient Days	1,380,761	34	11,203		27,377	222	2
3	3	Housekeeping	Patient Days	1,380,761	34	28,798		27,377	571	3
4	5	Utilities	Patient Days	1,380,761	34	40,168		27,377	796	4
5	6	Maintenance	Patient Days	1,380,761	34	83,922		27,377	1,664	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		27,377	1,666	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		27,377	3,325	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		27,377	541	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		27,377	3,356	9
10	24	Travel and Seminar	Patient Days	1,380,761	34	4,279		27,377	85	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		27,377	576	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		27,377	997	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		27,377	1,329	13
14	32	Interest	Patient Days	1,380,761	34	243,379		27,377	4,826	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		27,377	2,324	15
16	35	Rent - Equipment and Auto	Patient Days	1,380,761	34	27,451		27,377	544	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,217	\$		\$ 22,925	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 941 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	Patient Days	1,380,761	34	\$ 251,431	\$ 251,431	27,377	\$ 4,985	1
2	6	Maintenance	Direct	373,682	34	373,682	373,682			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,380,761	34	23,565		27,377	467	3
4	7	Emp. Ben. - Gen. Serv.	Direct	46,748	34	46,748				4
5	17	Administrative	Patient Days	1,380,761	34	478,172	478,172	27,377	9,481	5
6	21	Office and Clerical	Patient Days	1,380,761	34	2,897,656	2,897,656	27,377	57,453	6
7	21	Office and Clerical	Direct	460,382	34	460,382	460,382	13,119	13,119	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,380,761	34	617,434		27,377	12,242	8
9	27	Emp. Gen. - Gen. Admin.	Direct	73,413	34	73,413		1,157	1,157	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					\$ 5,222,483	\$ 4,461,323		\$ 98,904	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 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 VEBA
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22	Employee Benefits	Direct Allocation	7,877,989		\$ 7,877,989	\$	81,745	\$ 81,745	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					\$ 7,877,989	\$		\$ 81,745	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge Realty Capital		X	Mortgage	\$10,030.06	04/21/16	\$ 2,334,000	\$ 2,278,411		3.1500%	\$ 72,464	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	HFG		X	Line of Credit				1,481,720			27,441	6	
7	Alloc. - Extended Care		X	Line of Credit							4,826	7	
8			X	Auto Loan				37,171			2,929	8	
9	TOTAL Facility Related				\$10,030.06		\$ 2,334,000	\$ 3,797,302			\$ 107,660	9	
	B. Non-Facility Related*												
10												10	
11												11	
12	Interest Income		X								(497)	12	
13	Interest Income		X								(243)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (740)	14	
15	TOTALS (line 9+line14)						\$ 2,334,000	\$ 3,797,302			\$ 106,920	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,905 Line # 36 - 03

* 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' PREPARATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	26,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	27,491	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,391	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	26,425	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	27,816	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	21,687	8	FOR BHF USE ONLY	
		2012	23,375	9		
		2013	24,128	10	13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
		2014	24,900	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2015	25,167	12	15	LESS REFUND FROM LINE 6 \$ 15
2016 Real Estate Tax Accrual = \$25,167 * 1.05 = \$26,425					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Alloc. - Extended Care Consulting, LLC = \$2,324						

- NOTES:
- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
 - 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Village Hlthcare Ctr COUNTY Morgan
FACILITY IDPH LICENSE NUMBER 0042671
CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA
TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09 - 17 - 100 - 012</u>	<u>Long Term Care Facility</u>	\$ <u>25,166.88</u>	\$ <u>25,166.88</u>
2. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>167,518.13</u>	\$ <u>2,324.45</u>
3. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>36,794.68</u>	\$ <u>510.56</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><u>229,479.69</u></u>	\$ <u><u>28,001.89</u></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 providecopies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028

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

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	8,686	1997	\$ 170,000	1
2	Alloc. - Ext. Care			11,378	2
3	TOTALS	8,686		\$ 181,378	3

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	126		1997		\$ 1,114,539	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prairie Village Healthcare Center, Inc. (Operating Entity)										9
10											10
11	Various			2002	4,490						11
12	Various			2003	13,083						12
13	Various			2004	5,343						13
14	Various			2005	4,475						14
15	Various			2006	13,021						15
16	Various			2007	7,421						16
17	Various			2009	11,377						17
18	Various			2010	7,607						18
19	Various			2011	9,432						19
20	Various			2012	25,784						20
21	Alarm System			2014	4,784						21
22	Fire Sprinkler Heads			2014	6,500						22
23	Rooftop Carrier AC			2014	8,924						23
24	Boiler and Pump			2015	15,677						24
25	Addition - Carpentry, Millwork, Steel, Drywall, Concrete, Roofing, Doors,										25
26	Windows, Painting, Flooring, HVAC, Plumbing, Electrical, Fire Alarm,										26
27	Partitions			2015	76,895						27
28	Security System			2016	4,080						28
29	Compressors			2016	18,788						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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,110,466	\$		\$	\$	\$	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting, LLC	2007	91						5
6	Allocations - Extended Care Consulting, LLC	2009	55						6
7	Allocations - Extended Care Consulting, LLC	2010	535						7
8	Allocations - Extended Care Consulting, LLC	2011	193						8
9	Allocations - Extended Care Consulting, LLC	2013	63						9
10	Allocations - Extended Care Consulting, LLC	2014	879						10
11	Allocations - Extended Care Consulting, LLC	2016	1,054						11
12									12
13	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	15,680						13
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	12,953						14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	15,264						15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	758						16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	137						17
18	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	1,273						18
19	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	216						19
20	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	852						20
21									21
22	Allocations - Extended Care Consulting, LLC / Dyer Building	2007	4,759						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,165,228	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 283,359	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental	65,061						74
75	TOTALS	\$ 348,420	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	2015	\$ 58,932	\$	\$	\$		\$	76
77	Alloc. - Extended Care			3,578						77
78										78
79										79
80	TOTALS			\$ 62,510	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,757,536	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,516	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,537,798	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 13 - Related Party Furniture and Equipment Allocations

[illegible]

Facility Name & ID Number	Prairie Village Hlthcare Ctr
--------------------------------------	-------------------------------------

0042671

Report Period Beginning: 01/01/16

Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Suppl				0			5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO **Terms:** _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES☐ NO

16. Rental Amount for movable equipment: \$ **26,366**

Description:

See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Description		Amount		Total
Building Rental				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
		-		
Total		-		-
Equipment Rental				
Digital Copy Systems		2,939		2,939
Flynn Sales Services		10,000		10,000
Pitney Bowes		377		377
Quality Water Solution		1,380		1,380
Sunbelt Rentals		11,126		11,126
				-
Alloc. - Extended Care Consulting, LLC		544		544
				-
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				-
Total		26,366		26,366

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 332,414	\$		\$ 332,414	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			34,005			34,005	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			290,875			290,875	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				150,272		150,272	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					5,658		5,658	12
13	Other (specify): See Supplemental	39 - 03				41,930			41,930	13
14	TOTAL			\$		\$ 699,224	\$ 155,930		\$ 855,154	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 16 Supplemental Schedule

[illegible]

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	\$ 2,556	\$ 57,192	1
2	Cash-Patient Deposits	24,858	24,858	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 713,535)	406,015	406,015	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,620	44,556	6
7	Other Prepaid Expenses	6,222	6,222	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	20,534	195,574	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 489,805	\$ 734,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,114,539	14
15	Leasehold Improvements, at Historical Cost	222,455	1,980,701	15
16	Equipment, at Historical Cost	361,079	430,079	16
17	Accumulated Depreciation (book methods)	(302,452)	(1,435,012)	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): See Supplemental Schedule	2,699	82,787	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 283,781	\$ 2,343,094	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 773,586	\$ 3,077,511	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 345,958	\$ 345,958	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,858	24,858	28
29	Short-Term Notes Payable	1,481,720	1,481,720	29
30	Accrued Salaries Payable	118,777	118,777	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,949	5,949	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,425	32
33	Accrued Interest Payable		5,980	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	386,348	386,348	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,363,610	\$ 2,396,015	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	37,171	37,171	39
40	Mortgage Payable		2,278,411	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 37,171	\$ 2,315,582	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,400,781	\$ 4,711,597	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,627,195)	\$ (1,634,086)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 773,586	\$ 3,077,511	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Settlements - Third Party Payers		20,471				20,471
Due from Others		63				63
Escrow - Insurance				7,451		7,451
Escrow - Real Estate				21,500		21,500
Escrow - Litigation / Replacement				146,089		146,089
Sub-Total		20,534		175,040		195,574
Line 23 - Long Term Assets						
Financing Fees (Net of Amortization)		2,131				2,131
Replacement Tax Benefit		568				568
Financing Fees (Net of Amortization)				80,088		80,088
						-
						-
Sub-Total		2,699		80,088		82,787
Line 36 - Other Current Liability						
Due to Affiliated Entities		386,348				386,348
						-
						-
						-
						-
Sub-Total		386,348		-		386,348
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,383,165)	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)	\$ (1,383,164)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(244,031)	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)	\$ (244,031)	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)	\$ (1,627,195)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 4,755,817	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,755,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	302,322	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 302,322	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	497	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 497	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,058,636	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	840,843	31
32	Health Care	1,572,524	32
33	General Administration	1,304,830	33
	B. Capital Expense		
34	Ownership	343,510	34
	C. Ancillary Expense		
35	Special Cost Centers	1,018,483	35
36	Provider Participation Fee	222,477	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,302,667	40
41	Income before Income Taxes (line 30 minus line 40)**	(244,031)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (244,031)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,950,923	44
45	Private Pay - Net Inpatient Revenue	316,827	45
46	Medicare - Net Inpatient Revenue	1,044,483	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	321,629	47
48	Other-(specify) <u>Hospice - Net Patient Revenue</u>	121,955	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,755,817	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 19 Supplemental Schedule

Description		Amount		Total
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Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	1,997	2,129	\$ 74,534	\$ 35.01	1
2	Assistant Director of Nursing	1,944	2,159	52,262	24.21	2
3	Registered Nurses	2,227	2,558	70,334	27.50	3
4	Licensed Practical Nurses	20,643	22,253	467,214	21.00	4
5	CNAs & Orderlies	38,817	40,768	480,159	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,164	3,511	59,377	16.91	8
9	Activity Director	1,528	1,754	17,999	10.26	9
10	Activity Assistants	1,947	2,006	17,196	8.57	10
11	Social Service Workers	2,070	2,236	43,947	19.65	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,186	34,745	15.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,385	13,613	120,886	8.88	15
16	Dishwashers					16
17	Maintenance Workers	5,775	6,361	77,433	12.17	17
18	Housekeepers	9,848	10,864	95,172	8.76	18
19	Laundry	4,380	4,818	40,815	8.47	19
20	Administrator	1,961	2,065	89,606	43.39	20
21	Assistant Administrator					21
22	Other Administrative	410	410	45,008	109.78	22
23	Office Manager					23
24	Clerical	5,307	5,698	105,424	18.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,059	2,228	25,371	11.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	7,492	7,936	274,649	34.61	33
34	TOTAL (lines 1 - 33)	125,970	135,553	\$ 2,192,131 *	\$ 16.17	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		\$ 9,804	01 - 03	35
36	Medical Director		18,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,951	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		1,089	11 - 03	44
45	Social Service Consultant		1,419	12 - 03	45
46	Other(specify)				46
47	<u>See Supplemental Schedule</u>		18,000		47
48					48
49	TOTAL (lines 35 - 48)		\$ 51,263		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	1,949	2,116	17,500	8.27		
MDS / Care Plan Coordinator	10	3,085	3,297	93,009	28.21		
Transportation	14	36	74	811	10.96		
Non-Allowable	43	2,422	2,449	163,329	66.69		
					-		
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Total		7,492	7,936	274,649	34.61		

Contracted Services							
Art Therapist	12						18,000
Total						-	18,000

A. Administrative Salaries				Ownership	
Name	Function	%	Amount		
Jerri Springer	Administrator	0	\$ 89,606		
Sherwin Ray	Administration	33.33%	45,008		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 134,614		
B. Administrative - Other					
Description			Amount		
			\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		
C. Professional Services			Amount		
Vendor/Payee	Type				
Extended Care Consulting	Management Fee		\$ 120,000		
Plante & Moran, PLLC	Accounting		12,810		
Personnel Planners, Inc.	Unemployment Consultant		2,186		
Matrix Care	Data Processing / IT		15,768		
National Datacare Corporation	Data Processing / IT		1,744		
Ability Network	Data Processing / IT		3,980		
Propay Payroll Services	Data Processing / IT		13,614		
E-Health Data Solutions	Data Processing / IT		1,320		
Other Miscellaneous Vendors	Data Processing / IT		2,432		
McVey & Parks, LLC	Legal		12,274		
Falkenberg, Fieweger Ives, LLP	Legal		3,355		
See Supplemental Schedule			41,878		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 231,361		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 61,813		
Unemployment Compensation Insurance			34,159		
FICA Taxes			165,104		
Employee Health Insurance			58,825		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Other Employee Benefits			4,698		
Page 6B - Employee Benefit Offset			(3,936)		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 320,663		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description	Line #		Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$ 1,990		
Advertising: Employee Recruitment			1,200		
Health Care Worker Background Check			1,597		
(Indicate # of checks performed)					
Patient Background Checks					
Dues - ICLTC			15,811		
Dues and Subscriptions			4,630		
Licenses and Fees			1,268		
Advertising and Promotion			9,480		
Alloc. - Extended Care Consulting			541		
Less: Public Relations Expense			()		
Non-allowable advertising			(9,480)		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 27,037		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			1,042		
Alloc. - Extended Care Consulting			85		
Entertainment Expense			()		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 1,127		

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 21 Supplemental Schedule - Other Professional Fees[illegible]

Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	01/31/16		30	30	-
Simandl Law Group, SC	Non-Allowable	01/31/16		19,547	19,547	-
Simandl Law Group, SC	Non-Allowable	01/31/16		469	469	-
Simandl Law Group, SC	Non-Allowable	01/31/16		8,201	8,201	-
Simandl Law Group, SC	Non-Allowable	01/31/16		1,541	1,541	-
Simandl Law Group, SC	Non-Allowable	01/31/16		493	493	-
Simandl Law Group, SC	Non-Allowable	01/31/16		67	67	-
Simandl Law Group, SC	Non-Allowable	01/31/16		(4,101)	(4,101)	-
Simandl Law Group, SC	Non-Allowable	01/31/16		(771)	(771)	-
Simandl Law Group, SC	Non-Allowable	01/31/16		(9,965)	(9,965)	-
Simandl Law Group, SC	Non-Allowable	01/31/16		(235)	(235)	-
Simandl Law Group, SC	Non-Allowable	01/31/16		(247)	(247)	-
Holly Turner, Esq	Non-Allowable	01/31/16		238	238	-
Williams Montgomery & John, Ltd.	Non-Allowable	01/31/16		355	355	-
Williams Montgomery & John, Ltd.	Non-Allowable	01/31/16		339	339	-
Holly Turner, Esq	Non-Allowable	02/29/16		238	238	-
Williams Montgomery & John, Ltd.	Non-Allowable	02/29/16		1,292	1,292	-
Holly Turner, Esq	Non-Allowable	03/31/16		238	238	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	03/31/16		13	13	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	05/18/16		44	44	-
McVey & Parks, LLC	Non-Allowable	06/29/16		7,804	7,804	-
McVey & Parks, LLC	Resident Matters	06/29/16		2,025	-	2,025
McVey & Parks, LLC	Resident Matters	06/29/16		617	-	617
Arnstein & Lehr, LLP	Employment Matters	06/30/16		269	-	269
Williams Montgomery & John, Ltd.	Non-Allowable	06/30/16		1,332	1,332	-
Holly Turner, Esq	Non-Allowable	06/30/16		238	238	-
Williams Montgomery & John, Ltd.	Non-Allowable	06/30/16		1,119	1,119	-
Williams Montgomery & John, Ltd.	Non-Allowable	06/30/16		461	461	-
Holly Turner, Esq	Non-Allowable	06/30/16		238	238	-
Williams Montgomery & John, Ltd.	Non-Allowable	07/31/16		1,791	1,791	-
McVey & Parks, LLC	Resident Matters	07/31/16		1,390	-	1,390
McVey & Parks, LLC	Resident Matters	07/31/16		440	-	440
Williams Montgomery & John, Ltd.	Non-Allowable	08/22/16		1,168	1,168	-
Holly Turner, Esq	Non-Allowable	08/22/16		238	238	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	08/25/16		9	9	-
Jerri Springer	Non-Allowable	09/30/16		17	17	-
Holly Turner, Esq	Non-Allowable	08/31/16		296	296	-
Williams Montgomery & John, Ltd.	Non-Allowable	08/31/16		83	83	-
Falkenberg, Fieweger & Ives, LLP	Non-Allowable	09/30/16		765	765	-
Falkenberg, Fieweger & Ives, LLP	Non-Allowable	11/30/16		1,560	1,560	-
Holly Turner, Esq	Non-Allowable	11/30/16		238	238	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	12/31/16		35	35	-
Holly Turner, Esq	Non-Allowable	12/31/16		267	267	-
Falkenberg, Fieweger & Ives, LLP	Non-Allowable	12/31/16		1,030	1,030	-
Holly Turner, Esq	Non-Allowable	12/31/16		238	238	-
Holly Turner, Esq	Non-Allowable	12/31/16		238	238	-
Total					41,693	36,953

XX. GENERAL INFORMATION:

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

No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
ICLTC - \$15,811
- (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?

No
N/A
- (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?

No
N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$5,934
Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9) Are you presently operating under a sublease agreement?

YESXNO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNOX
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (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.

\$222,477
- (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.

No
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$0
No
Indicate the amount. \$0
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

Ln 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

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

No
N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

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

Yes

SEE ACCOUNTANTS' PREPARATION REPORT