

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>148</u>	Skilled (SNF)	<u>148</u>	<u>54,020</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>148</u>	TOTALS	<u>148</u>	<u>54,020</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>23,200</u>	<u>7,742</u>	<u>16,937</u>	<u>47,879</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,200</u>	<u>7,742</u>	<u>16,937</u>	<u>47,879</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.63%

D. How many bed-hold days during this year were paid by the Department? 16 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/2002

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 148 and days of care provided 16,446

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	295,222	58,465	17,203	370,890		370,890	6,032	376,922		1
2	Food Purchase		263,402		263,402		263,402	98	263,500		2
3	Housekeeping	236,199	53,500		289,699		289,699	(2,804)	286,895		3
4	Laundry	74,734	23,045		97,779		97,779	(563)	97,216		4
5	Heat and Other Utilities			177,906	177,906		177,906	2,330	180,236		5
6	Maintenance	126,486		164,326	290,812		290,812	18,919	309,731		6
7	Other (specify):*							2,515	2,515		7
8	TOTAL General Services	732,641	398,412	359,435	1,490,488		1,490,488	26,528	1,517,016		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	2,909,945	192,175	17,261	3,119,381		3,119,381	16,398	3,135,779		10
10a	Therapy	222,048		1,603	223,651		223,651	1,600	225,251		10a
11	Activities	230,287	23,971	350	254,608		254,608		254,608		11
12	Social Services	184,129		1,733	185,862		185,862	8,608	194,470		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,273	7,273		15
16	TOTAL Health Care and Programs	3,546,409	216,146	62,947	3,825,502		3,825,502	33,879	3,859,381		16
	C. General Administration										
17	Administrative	149,437		10,200	159,637		159,637	52,544	212,181		17
18	Directors Fees										18
19	Professional Services			457,249	457,249	(9,852)	447,397	(383,609)	63,788		19
20	Dues, Fees, Subscriptions & Promotions			52,795	52,795		52,795	(27,966)	24,829		20
21	Clerical & General Office Expenses	151,267	42,835	360,533	554,635		554,635	(162,234)	392,401		21
22	Employee Benefits & Payroll Taxes			751,461	751,461		751,461	(8,004)	743,457		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,773	7,773		7,773	1,004	8,777		24
25	Other Admin. Staff Transportation			6,226	6,226		6,226	539	6,765		25
26	Insurance-Prop.Liab.Malpractice			293,055	293,055		293,055	1,478	294,533		26
27	Other (specify):*							31,806	31,806		27
28	TOTAL General Administration	300,704	42,835	1,939,292	2,282,831	(9,852)	2,272,979	(494,442)	1,778,537		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,579,754	657,393	2,361,674	7,598,821	(9,852)	7,588,969	(434,035)	7,154,934		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center #0046011 Report Period Beginning: 01/01/09 Ending: 12/31/09

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			91,155	91,155		91,155	107,532	198,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,200	1,200		1,200	296,301	297,501			32
33	Real Estate Taxes			460,068	460,068	9,852	469,920	2,149	472,069			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(432,803)	5,197			34
35	Rent-Equipment & Vehicles			7,594	7,594		7,594	2,394	9,988			35
36	Other (specify):*											36
37	TOTAL Ownership			998,017	998,017	9,852	1,007,869	(24,427)	983,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		938,156	1,648,209	2,586,365		2,586,365	(73,600)	2,512,765			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,030	81,030		81,030		81,030			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		938,156	1,729,239	2,667,395		2,667,395	(73,600)	2,593,795			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,579,754	1,595,549	5,088,930	11,264,233		11,264,233	(532,063)	10,732,170			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(40,235)	30		9
10	Interest and Other Investment Income	(50,111)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(426)	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	(179,976)	21		24
25	Fund Raising, Advertising and Promotional	(25,036)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(142)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(168)	20		28
29	Other-Attach Schedule	(145,082)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (441,176)		\$	30

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	2	
		Amount	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)	(90,887)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (90,887)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (532,063)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Manor Nursing & Rehab Center

ID# 0046011

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty	\$ (138)	10	1
2	Theft	(2,776)	21	2
3	Collection Expenses	(1,302)	21	3
4	Non-Allowable Expenses	(300)	21	4
5	Annual Report	(250)	20	5
6	COPE Dues	(4,569)	20	6
7	Marketing Inservice	(100)	21	7
8	Building Co.- Bank Charges	(5)	21	8
9	Building Co.- Filling Fees	(250)	21	9
10	Building Co.- Amortization	(615)	36	10
11	Other Income	(11,614)	21	11
12	Other Income	(880)	01	12
13	Non-Allowable Expenses	(109,800)	21	13
14	Non-Allowable Legal Expenses	(6,655)	19	14
15	Additional R&M	4,000	06	15
16	Professional Fees Credits	(9,828)	19	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	(145,082)		49

Prairie Manor Nursing & Rehab CenterID# 0046011Report Period Beginning: 01/01/09Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(880)		236		4,089				2,587			6,032	1
2	Food Purchase	(426)		524									98	2
3	Housekeeping			489		54	(3,347)						(2,804)	3
4	Laundry						(563)						(563)	4
5	Heat and Other Utilities			2,006		128				196			2,330	5
6	Maintenance	4,000		3,113	7,626	17	(287)		4,300	150			18,919	6
7	Other (specify):*				1,922	593							2,515	7
8	TOTAL General Services	2,694		6,368	9,548	4,881	(4,196)		4,300	2,933			26,528	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(138)				27,565	(11,030)						16,398	10
10a	Therapy					1,600							1,600	10a
11	Activities													11
12	Social Services					8,608							8,608	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,273							7,273	15
16	TOTAL Health Care and Programs	(138)				45,046	(11,030)						33,879	16
	C. General Administration													
17	Administrative			2,296	8,326	36,304				5,618			52,544	17
18	Directors Fees													18
19	Professional Services	(16,483)		(286,989)		(80,582)			236	209			(383,609)	19
20	Fees, Subscriptions & Promotions	(30,023)		1,965		7				85			(27,966)	20
21	Clerical & General Office Expenses	(306,265)	255	16,086	125,232	8,141			(12,483)	6,800			(162,234)	21
22	Employee Benefits & Payroll Taxes				(4,290)	(3,369)	(345)						(8,004)	22
23	Inservice Training & Education													23
24	Travel and Seminar			62		942							1,004	24
25	Other Admin. Staff Transportation			359					19	161			539	25
26	Insurance-Prop.Liab.Malpractice			789		47			243	399			1,478	26
27	Other (specify):*				23,047	6,307				2,452			31,806	27
28	TOTAL General Administration	(352,771)	255	(265,432)	152,315	(32,203)	(345)		(11,985)	15,724			(494,442)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(350,215)	255	(259,064)	161,863	17,724	(15,570)		(7,685)	18,657			(434,035)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	D. Ownership													
	Depreciation	(40,235)	120,800	4,020		890			21,647	410			107,532	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(50,111)	272,783	59,098		10,756			3,775				296,301	32
33	Real Estate Taxes			1,938		211							2,149	33
34	Rent-Facility & Grounds		(438,000)	3,362						1,835			(432,803)	34
35	Rent-Equipment & Vehicles			2,375						19			2,394	35
36	Other (specify):*	(615)	615											36
37	TOTAL Ownership	(90,961)	(43,802)	70,793		11,857			25,422	2,264			(24,427)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(11,098)		(43,695)	(18,807)			(73,600)	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						(11,098)		(43,695)	(18,807)			(73,600)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(441,176)	(43,547)	(188,271)	161,863	29,581	(26,669)		(25,958)	2,114			(532,063)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Prairie Manor Healthcare Properties		Building Co

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 438,000	Prairie Manor Healthcare Properties	100.00%	\$	\$ (438,000)	1
2	V	32 Interest Income	366	Prairie Manor Healthcare Properties	100.00%		(366)	2
3	V	21 Bank Service Charges		Prairie Manor Healthcare Properties	100.00%	5	5	3
4	V	21 Filling Fee		Prairie Manor Healthcare Properties	100.00%	250	250	4
5	V	30 Depreciation		Prairie Manor Healthcare Properties	100.00%	120,800	120,800	5
6	V	36 Amortization		Prairie Manor Healthcare Properties	100.00%	615	615	6
7	V	32 Interest Expenses		Prairie Manor Healthcare Properties	100.00%	273,149	273,149	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,366			\$ 394,819	\$ * (43,547)	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%	\$ 236	\$	236	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	524		524	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	489		489	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	2,006		2,006	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,113		3,113	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,296		2,296	20
21	V	19 Professional Fees	296,922	Extended Care Consulting, LLC	100.00%	9,933		(286,989)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,965		1,965	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	16,086		16,086	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	62		62	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	359		359	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	789		789	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,020		4,020	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	59,098		59,098	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,938		1,938	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	3,362		3,362	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,375		2,375	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 296,922			\$ 108,651	\$ *	(188,271)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,626	\$	7,626	15
16	V	06 Maintenance (Direct)	5,875	Extended Care Consulting, LLC	100.00%	5,875			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,305		1,305	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	617		617	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,326		8,326	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	125,232		125,232	20
21	V	21 Office and Clerical (Direct)	15,433	Extended Care Consulting, LLC	100.00%	15,433			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,427		21,427	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,620		1,620	23
24	V	22 Employee Benefits	4,290	Extended Care Consulting, LLC	100.00%			(4,290)	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		\$ 25,598			\$ 187,461	\$ *	161,863	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 54	\$	54	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	128		128	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	17		17	17
18	V	19 Professional Fees	81,699	Extended Care Clinical, LLC	100.00%	1,117		(80,582)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	7		7	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	950		950	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	942		942	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	47		47	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	890		890	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	10,756		10,756	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	211		211	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,089		4,089	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	593		593	27
28	V	10 Nursing Salary	15,260	Extended Care Clinical, LLC	100.00%	42,825		27,565	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,600		1,600	29
30	V	12 Social Service Salary	1,733	Extended Care Clinical, LLC	100.00%	10,341		8,608	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,273		7,273	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	36,304		36,304	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	7,191		7,191	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,307		6,307	34
35	V	22 Employee Benefits	3,369	Extended Care Clinical, LLC	100.00%			(3,369)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 102,061			\$ 131,642	\$ *	29,581	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	36,443	Xcel Supply, LLC	100.00%	33,097	(3,347)	16
17	V	4 Laundry	6,127	Xcel Supply, LLC	100.00%	5,564	(563)	17
18	V	6 Repairs & Maintenance	3,123	Xcel Supply, LLC	100.00%	2,836	(287)	18
19	V	10 Nursing	120,106	Xcel Supply, LLC	100.00%	109,076	(11,030)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	3,754	Xcel Supply, LLC	100.00%	3,409	(345)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	120,855	Xcel Supply, LLC	100.00%	109,757	(11,098)	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		\$ 290,408			\$ 263,739	\$ * (26,669)	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%	\$ 108,762	\$ 108,762
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	108,762	CCS Employee Benefits Group	100.00%		(108,762)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
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		\$ 108,762			\$ 108,762	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 4,300	\$ 4,300
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	236	236
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	365	365
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	19	19
19	V	26 Insurance		Vent Lease, LLC.	100.00%	243	243
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	11,190	11,190
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,885	1,885
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	10,457	10,457
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,890	1,890
24	V	21 Office and Clerical	12,848	Vent Lease, LLC.	100.00%		(12,848)
25	V	39 Ancillary	43,695	Vent Lease, LLC.	100.00%		(43,695)
26	V						
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		\$ 56,543			\$ 30,585	\$ * (25,958)

* 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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,587	\$	2,587	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	196		196	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	150		150	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	209		209	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	85		85	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,064		1,064	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	161		161	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	399		399	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	410		410	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%				26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	1,835		1,835	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	19		19	28
29	V	01 Dietary		Care Centers Health Systems, Inc.	100.00%				29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%				30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%				32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%				33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%				34
35	V	39 Ancillary	31,303	Care Centers Health Systems, Inc.	100.00%	12,496		(18,807)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	5,618		5,618	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	5,736		5,736	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	2,452		2,452	38
39	Total		\$ 31,303			\$ 33,417	\$ *	2,114	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	Eric Rothner	Shareholder	Administrative	1.00%	See Attached	1.04	3.47%	Salary	\$ 10,200	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.91	3.47%	Alloc. Salary	5,794	17-7	2
3	Adam Vales	Shareholder	Clerical	11.00%	See Attached	0.63	1.58%	Alloc. Salary	1,141	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,135		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' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	30	\$ 6,770	\$	47,879	\$ 236	1
2	02	Food	Patient Days	30	15,058		47,879	524	2
3	03	Housekeeping	Patient Days	30	14,059		47,879	489	3
4	05	Utilities	Patient Days	30	57,646		47,879	2,006	4
5	06	Maintenance	Patient Days	30	89,465		47,879	3,113	5
6	17	Administrative	Patient Days	30	66,000		47,879	2,296	6
7	19	Professional Fees	Patient Days	30	285,482		47,879	9,933	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		47,879	1,965	8
9	21	Office and Clerical	Patient Days	30	462,313		47,879	16,086	9
10	24	Seminar and Travel	Patient Days	30	1,768		47,879	62	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		47,879	359	11
12	26	Insurance	Patient Days	30	22,668		47,879	789	12
13	30	Depreciation	Patient Days	30	115,549		47,879	4,020	13
14	32	Interest	Patient Days	30	1,698,489		47,879	59,098	14
15	33	Real Estate Taxes	Patient Days	30	55,709		47,879	1,938	15
16	34	Rent - Building	Patient Days	30	96,636		47,879	3,362	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		47,879	2,375	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 108,651	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	30	219,177	219,177	47,879	7,626	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		5,875	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		47,879	1,305	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		617	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	47,879	8,326	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	47,879	125,232	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			15,433	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	47,879	21,427	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	47,879	1,620	9
10	22	Employee Benefits							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				\$ 5,530,203	\$ 4,838,529		\$ 187,461	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	30	\$ 1,549	\$	47,879	\$ 54	1
2	05	Utilities	Patient Days	30	3,693		47,879	128	2
3	06	Maintenance	Patient Days	30	477		47,879	17	3
4	19	Professional Fees	Patient Days	30	32,105		47,879	1,117	4
5	20	Dues and Subscriptions	Patient Days	30	213		47,879	7	5
6	21	Office & Clerical	Patient Days	30	27,296		47,879	950	6
7	24	Travel and Seminar	Patient Days	30	27,079		47,879	942	7
8	26	Insurance	Patient Days	30	1,342		47,879	47	8
9	30	Depreciation	Patient Days	30	25,586		47,879	890	9
10	32	Interest	Patient Days	30	309,136		47,879	10,756	10
11	33	Real Estate Taxes	Patient Days	30	6,053		47,879	211	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	47,879	4,089	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		47,879	593	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	47,879	27,832	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	47,879	1,600	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	47,879	8,608	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		47,879	5,516	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	47,879	36,304	18
19	21	Office Salary	Patient Days	30	206,680	206,680	47,879	7,191	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		47,879	6,307	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	47,879	14,993	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		1,733	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			1,757	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 131,642	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					33,097	2
3	4	Laundry	Direct Allocation					5,564	3
4	6	Repairs & Maintenance	Direct Allocation					2,836	4
5	10	Nursing	Direct Allocation					109,076	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					3,409	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					109,757	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				\$	\$		\$	263,739

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 108,762	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				\$	\$		\$ 108,762	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	Repairs	Direct Billing	821,185	26	\$ 80,807	\$ 43,695	\$ 4,300	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	43,695	236	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	43,695	365	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	43,695	19	4
5	26	Insurance	Direct Billing	821,185	26	4,573	43,695	243	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	43,695	11,190	6
7	32	Interest	Direct Billing	821,185	26	35,420	43,695	1,885	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	47,879	10,457	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	47,879	1,890	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					\$ 706,114	\$	\$ 30,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/09Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Care Centers Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 612-5662

Fax Number

(224) 612-5862

1	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	Gross Billable Income	3,421,940	26	72,652	121,845	2,587	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		121,845		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	121,845	196	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	121,845	150	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	121,845	209	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	121,845	85	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	121,845	1,064	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	121,845	161	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	121,845	399	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	121,845	410	10
11	32	Interest	Gross Billable Income	3,421,940	26		121,845		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		121,845		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	121,845	1,835	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	121,845	19	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445			15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	31,303	12,496	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	5,618	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	5,736	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	121,845	2,452	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 33,417	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	First Choice		X	First Mortgage			\$	\$ 4,157,849			\$ 269,936	1								
2	First Choice		X	Second Mortgage				51,409			3,213	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6	Daiwa		X	Line of Credit							1,200	6								
7												7								
8	See Supplemental Schedule										73,629	8								
9	TOTAL Facility Related						\$	\$ 4,209,258			\$ 347,978	9								
	B. Non-Facility Related*																			
10	Interest Income		X								(50,111)	10								
11	Interest Income Bldg. Co.		X								(366)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (50,477)	14								
15	TOTALS (line 9+line14)						\$	\$ 4,209,258			\$ 297,501	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Alloc from Ext Care Const, Inc	X								59,098	8									
9	Alloc from Ext Care Clinical	X								10,756	9									
10	Alloc from Vent Lease	X								3,775	10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										73,629	14								
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

(See instructions.)

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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		2002	\$ 450,000	1
2	Alloc. from Ext. Care Conslt/ Ext Care Clincnl 2201 Main			12,769	2
3	TOTALS			\$ 462,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		33,716		20	1,524	1,524	12,732	9
10	Various		2004		215,253		20	13,193	13,193	79,990	10
11	Various		2005		96,468		20	12,630	12,630	58,785	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	4,650,000	120,800		119,231	(1,569)	825,662	67
68	Related Party Allocations (Pages 12H & 12I)	50,525	3,451		3,451		21,020	68
69	Financial Statement Depreciation		90,252			(90,252)		69
70	TOTAL (lines 4 thru 69)	\$ 5,045,962	\$ 214,503		\$ 150,029	\$ (64,474)	\$ 998,189	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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		\$ 5,045,962	\$ 214,503		\$ 150,029	\$ (64,474)	\$ 998,189	1
2	Midwest Health Care Systems J&J Glass Co	2006	2,590		20	130	130	496	2
3	Remodel 6 Shower Rooms	2006	8,750		20	438	438	1,677	3
4	Remodel 2 Dialysis Rooms	2006	5,500		20	275	275	1,054	4
5	Installation Of Two Domestic Boilers	2006	8,623		20	431	431	1,617	5
6	Installation Of Two Domestic Boilers	2006	8,623		20	431	431	1,581	6
7	Midwest Mechanical Group #3	2006	7,122		20	356	356	1,276	7
8	The Home Depot	2006	5,064		20	253	253	907	8
9	J&J Glass Co	2006	2,757		20	138	138	494	9
10	Nd Industrial Services	2006	4,350		20	218	218	761	10
11	Midwest Mechanical Group#4	2006	7,122		20	356	356	1,246	11
12	Due To Westshire	2006	8,750		20	438	438	1,495	12
13	Condensor Fan Work-Window Replacement	2006	3,064		20	613	613	2,349	13
14	Midwest Mechanical Group#4	2006	7,122		20	356	356	1,217	14
15	Century Tile	2006	3,705		20	185	185	602	15
16	Midwest Mechanical Group#4	2006	7,122		20	356	356	1,157	16
17	4 Shower Rooms, Shower Doors	2007	10,959		20	548	548	1,553	17
18	Patched Parking Lot	2007	10,000		20	500	500	1,125	18
19	4 Shower Rooms	2007	35,250		20	1,763	1,763	5,288	19
20	Hot Tub	2008	3,000		20	150	150	300	20
21	New Windows	2008	3,461		20	173	173	346	21
22	New Windows	2008	3,069		20	153	153	256	22
23	New Doors	2008	6,520		20	326	326	489	23
24	2 Boilers	2008	9,300		20	775	775	1,163	24
25	New Windows	2008	2,684		20	134	134	179	25
26	Fire Protected Ceiling Tiles	2008	3,185		20	159	159	199	26
27	Fire Protected Ceiling Tiles	2009	4,237		20	212	212	212	27
28	Windows	2009	6,663		20	250	250	250	28
29	Windows	2009	5,196		20	173	173	173	29
30	Roof Repairs	2009	3,565		20	89	89	89	30
31	Replace Smoke Damper Motors	2009	11,153		20	929	929	929	31
32	Masonry And Concrete Repair	2009	12,500		20	52	52	52	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,266,968	\$ 214,503		\$ 161,389	\$ (53,114)	\$ 1,028,721	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Prairie Manor HC Property	1988	4,650,000	120,800	39	119,231	(1,569)	825,662	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 4,650,000	\$ 120,800		\$ 119,231	\$ (1,569)	\$ 825,662	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	15,851	406	39	406		2,964	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,746	45	39	45		326	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,094	1,197	20	1,197		7,191	9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2003	15,431	1,410	20	1,410		8,475	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2005	767	81	20	81		276	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2009	138	7	20	7		7	12
13									13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	160	3	20	3		19	15
16	Allocated from Extended Care Consulting, LLC	2009	96	5	20	5		5	16
17									17
18									18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,443	132	20	132		792	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,700	155	20	155		934	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	84	9	20	9		30	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	15	1	20	1		1	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 50,525	\$ 3,451		\$ 3,451	\$	\$ 21,020	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 197,854	\$ 22,343	\$ 31,659	\$ 9,316	10	\$ 154,461	71
72	Current Year Purchases	30,268	289	3,852	3,563	10	3,852	72
73	Fully Depreciated Assets	1,360,728				10	1,360,728	73
74								74
75	TOTALS	\$ 1,588,850	\$ 22,632	\$ 35,511	\$ 12,879		\$ 1,519,041	75

D. Vehicle Depreciation (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		Alloc. from EC Clinical	2009	\$ 2,501	\$ 500	\$ 500		5	\$ 1,473	76
77		Alloc. from ECC	2009	11,189	175	175		5	10,664	77
78		Alloc. from CC Health Systems	1900	1,043	209	209		5	314	78
79										79
80	TOTALS			\$ 14,733	\$ 884	\$ 884			\$ 12,451	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)	\$ 7,333,320	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 238,019	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,784	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (40,235)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,560,213	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' COMPILATION REPORT

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 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	<u>Alloc. From Extended Care Consulting</u>			<u>3,362</u>			5
6	<u>Alloc. From Extended Care Clinical</u>			<u>1,835</u>			6
7	TOTAL			\$ 5,197			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: \$ 9,989 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	565,381	\$		\$	565,381	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				191,548				191,548	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				882,976				882,976	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					630,477			630,477	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						8,304	307,679			315,983	13
14	TOTAL			\$		\$	1,648,209	\$	938,156	\$	2,586,365	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 112,399	1
2	Cash-Patient Deposits	53,473	53,473	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	767,142	767,142	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	315,067	315,067	6
7	Other Prepaid Expenses	2,262	2,262	7
8	Accounts Receivable (owners or related parties)	592,637	592,637	8
9	Other(specify): <u>See Attached Schedule</u>	1,855,993	1,953,015	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,587,574	\$ 3,795,995	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,550,000	14
15	Leasehold Improvements, at Historical Cost	429,564	529,564	15
16	Equipment, at Historical Cost	381,849	1,581,849	16
17	Accumulated Depreciation (book methods)	(471,199)	(2,560,005)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		39,968	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(36,944)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 340,214	\$ 4,554,432	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,927,788	\$ 8,350,427	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,069,819	\$ 2,069,819	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,027	39,027	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,646	303,646	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,226	12,226	31
32	Accrued Real Estate Taxes(Sch.IX-B)	477,664	477,664	32
33	Accrued Interest Payable		18,308	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	262,457	1,816,645	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,164,839	\$ 4,737,335	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,209,258	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,209,258	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,164,839	\$ 8,946,593	46
47	TOTAL EQUITY(page 18, line 24)	\$ 762,949	\$ (596,166)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,927,788	\$ 8,350,427	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,870,483	1
2	Restatements (describe):		2
3	Daiwa Loan Write Off	(5,033,943)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (163,460)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	926,409	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)	\$ 926,409	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)	\$ 762,949	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/09Ending: 12/31/09

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,955,579	1
2	Discounts and Allowances for all Levels	(6,645,385)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,310,194	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,014,130	6
7	Oxygen	1,302	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,015,432	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	866	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	643,525	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,855	19
20	Radiology and X-Ray	10,370	20
21	Other Medical Services	69,829	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 792,445	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	50,111	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,111	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	22,460	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,460	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,190,642	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,490,488	31
32	Health Care	3,825,502	32
33	General Administration	2,282,831	33
B. Capital Expense			
34	Ownership	998,017	34
C. Ancillary Expense			
35	Special Cost Centers	2,586,365	35
36	Provider Participation Fee	81,030	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,264,233	40
41	Income before Income Taxes (line 30 minus line 40)**	926,409	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 926,409	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

0046011

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,912	2,242	\$ 107,093	\$ 47.77	1
2	Assistant Director of Nursing	1,776	2,059	74,621	36.24	2
3	Registered Nurses	17,028	19,114	600,750	31.43	3
4	Licensed Practical Nurses	41,204	45,062	1,055,959	23.43	4
5	CNAs & Orderlies	90,829	103,707	982,062	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,947	16,545	222,048	13.42	8
9	Activity Director	3,409	3,750	76,434	20.38	9
10	Activity Assistants	15,138	17,324	153,853	8.88	10
11	Social Service Workers	7,557	8,534	184,129	21.58	11
12	Dietician	693	695	11,531	16.59	12
13	Food Service Supervisor	1,939	2,153	45,565	21.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,524	6,705	79,833	11.91	15
16	Dishwashers	15,078	17,251	158,293	9.18	16
17	Maintenance Workers	6,227	7,018	126,486	18.02	17
18	Housekeepers	22,701	26,342	236,199	8.97	18
19	Laundry	6,805	7,689	74,734	9.72	19
20	Administrator	1,976	2,190	99,923	45.63	20
21	Assistant Administrator	1,991	2,171	49,514	22.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,575	8,547	151,267	17.70	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	3,514	4,010	59,989	14.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,006	2,252	29,471	13.09	33
34	TOTAL (lines 1 - 33)	268,829	305,360	\$ 4,579,754 *	\$ 15.00	34

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

** See instructions.

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	379	\$ 17,203	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,001	10-03	39
40	Physical Therapy Consultant	4	1,603	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	350	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached</u>	342	15,260		47
48	<u>See Attached</u>	47	1,733		48
49	TOTAL (lines 35 - 48)	778	\$ 80,150		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Charles Slafle	Administrator		\$ 99,923	Workers' Compensation Insurance	\$ 131,318	IDPH License Fee	\$		
Phil Baratta	Assist. Admin.		49,514	Unemployment Compensation Insurance	40,035	Advertising: Employee Recruitment		5,578	
				FICA Taxes	341,914	Health Care Worker Background Check (Indicate # of checks performed _____)		4,029	
				Employee Health Insurance	160,546	Patient Background Checks			
				Employee Meals		License and Fees		1,533	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions		11,632	
				Employee Physicals	14,219	COPE Dues		4,569	
				Pension Expenses	40,752	Alloc from Ext. Care Consulting		1,965	
				Other Employee Welfare	12,687	See Supplemental Schedule		92	
				Holiday Expenses	1,985	Less: Public Relations Expense		(4,569)	
						Non-allowable advertising	(
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 149,437	TOTAL (agree to Schedule V, line 22, col.8)		\$ 743,457	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,829
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	
Eric Rothner - Management Fees			\$ 10,200				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 10,200				In-State Travel		
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached	Legal		\$ 12,973						
FR&R	Accounting		20,267						
Personnel Planners	Unemployment Conslut		4,300						
Extended Care Centers, Inc	Home Office Expenses		296,922						
Extended Care Clinical	Home Office Expenses		81,699						
ADP	Payroll Processing		1,172						
E-Health Data Solution	MDS Software		3,180						
National Datacare Corp	Data Processing		1,311						
ITT/Sourcetechn	Data Processing		660						
Allegiance	Employee Compliance		56						
Prospect Resources	Natural Gas Procurment		760						
See Supplemental Schedule			33,950						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 457,249	TOTAL		\$	Seminar Expense	915	
							Education Expenses	3,866	
							Inservice Expenses	2,992	
							See Supplemental Schedule	1,004	
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 8,777	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$11,233 & IAHC \$1,332
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,788 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 81,030
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.