

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,220	948	2,809	14,977	8
9	SNF/PED					9
10	ICF	7,884			7,884	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,104	948	2,809	22,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.71%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 05/01/97

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

YES Date 05/01/97 NO

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

YES NO If YES, enter number of beds certified 53 and days of care provided 2,809

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	148,613	15,971	7,306	171,890		171,890	(909)	170,981		1
2	Food Purchase		140,044		140,044		140,044	263	140,307		2
3	Housekeeping	92,682	14,830		107,512		107,512	264	107,776		3
4	Laundry	40,172	11,137		51,309		51,309		51,309		4
5	Heat and Other Utilities			97,011	97,011		97,011	348	97,359		5
6	Maintenance	73,591		80,906	154,497		154,497	6,607	161,104		6
7	Other (specify):* See Supplemental			104	104		104	444	548		7
8	TOTAL General Services	355,058	181,982	185,327	722,367		722,367	7,017	729,384		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,076,393	53,564	5,075	1,135,032		1,135,032		1,135,032		10
10a	Therapy	19,886			19,886		19,886		19,886		10a
11	Activities	42,680	3,546		46,226		46,226	(58)	46,168		11
12	Social Services	52,397		5,751	58,148		58,148		58,148		12
13	CNA Training										13
14	Program Transportation			14	14		14		14		14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,191,356	57,110	28,840	1,277,306		1,277,306	(58)	1,277,248		16
	C. General Administration										
17	Administrative	99,339			99,339		99,339	11,365	110,704		17
18	Directors Fees										18
19	Professional Services			212,350	212,350		212,350	(126,281)	86,069		19
20	Dues, Fees, Subscriptions & Promotions			21,564	21,564		21,564	(9,433)	12,131		20
21	Clerical & General Office Expenses	70,895	9,851	450,697	531,443		531,443	(365,187)	166,256		21
22	Employee Benefits & Payroll Taxes			285,480	285,480		285,480	(4,793)	280,687		22
23	Inservice Training & Education			1,329	1,329		1,329		1,329		23
24	Travel and Seminar			1,067	1,067		1,067	200	1,267		24
25	Other Admin. Staff Transportation			16,538	16,538		16,538	529	17,067		25
26	Insurance-Prop.Liab.Malpractice			137,348	137,348		137,348	8,538	145,886		26
27	Other (specify):* See Supplemental							14,694	14,694		27
28	TOTAL General Administration	170,234	9,851	1,126,373	1,306,458		1,306,458	(470,368)	836,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,716,648	248,943	1,340,540	3,306,131		3,306,131	(463,409)	2,842,722		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.

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security			104
Alloc. Extended Care Consulting, LLC			444
Total	-	-	548
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Alloc. Extended Care Consulting, LLC			14,694
Total	-	-	14,694

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
Care Consulting of Illinois	6,808	6,808
Trista Crabtree	164	164
Cummins Crosspoint	788	788
Cindy Wardle	48	48
Laura Sepessy	2,496	2,496
Kelly Rothering	6,148	6,148
West Central Mass Transit	86	86
Alloc. Extended Care Consulting, LLC	529	529
Page 5 Adjustment		
	17,067	17,067

Facility Name & ID Number Prairie Village Hlthcare Ctr

#0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			5,327	5,327		5,327	59,178	64,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			808	808		808	115,705	116,513			32
33	Real Estate Taxes							26,939	26,939			33
34	Rent-Facility & Grounds			278,916	278,916		278,916	(278,221)	695			34
35	Rent-Equipment & Vehicles			15,834	15,834		15,834	500	16,334			35
36	Other (specify):* See Supplemental							11,827	11,827			36
37	TOTAL Ownership			300,885	300,885		300,885	(64,072)	236,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,143	451,051	621,194		621,194		621,194			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			190,847	190,847		190,847		190,847			42
43	Other (specify):* See Supplemental	150,411			150,411		150,411	(150,411)				43
44	TOTAL Special Cost Centers	150,411	170,143	641,898	962,452		962,452	(150,411)	812,041			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,867,059	419,086	2,283,323	4,569,468		4,569,468	(677,892)	3,891,576			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

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Prairie Village Healthcare Center, LLC			
Mortgage Insurance Premiums			11,827
Total	-	-	11,827
Line 43 Detailed			
Non-Allowable Expenses			
	150,411		
Total	150,411	-	-

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				9
10	Interest and Other Investment Income	(14,491)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,058)	01		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	(13)	21		18
19	Entertainment				19
20	Contributions	(40)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(419,266)	21		24
25	Fund Raising, Advertising and Promotional	(10,950)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(185,107)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (630,925)		\$	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)	(46,967)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,967)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (677,892)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Village Hlthcare Ctr

ID# 0042671

Report Period Beginning: 01/01/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (58)	11	1
2	Bank Charges	(10,813)	21	2
3	Theft	(75)	21	3
4	Collections	(1,836)	21	4
5	Other Expense	(1,112)	21	5
6	Non-Allowable Legal	(10,703)	19	6
7	Non-Allowable Salary	(150,411)	43	7
8				8
9				9
10	Prairie Village Healthcare Center, LLC			10
11	Professional Fees	(7,250)	19	11
12	Office	(293)	21	12
13	Amortization	(2,556)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(185,107)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	(1,058)	0	149	0	0	0	0	0	0	0	0	(909)	1
2	Food Purchase	0	0	263	0	0	0	0	0	0	0	0	263	2
3	Housekeeping	0	0	264	0	0	0	0	0	0	0	0	264	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	348	0	0	0	0	0	0	0	0	348	5
6	Maintenance	0	0	2,273	4,334	0	0	0	0	0	0	0	6,607	6
7	Other (specify):*	0	0	0	444	0	0	0	0	0	0	0	444	7
8	TOTAL General Services	(1,058)	0	3,297	4,778	0	7,017	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(58)	0	0	0	0	0	0	0	0	0	0	(58)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(58)	0	0	0	0	0	0	0	0	0	0	(58)	16
	C. General Administration													
17	Administrative	0	0	1,743	9,622	0	0	0	0	0	0	0	11,365	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,953)	7,250	(115,578)	0	0	0	0	0	0	0	0	(126,281)	19
20	Fees, Subscriptions & Promotions	(10,990)	0	1,557	0	0	0	0	0	0	0	0	(9,433)	20
21	Clerical & General Office Expenses	(433,408)	293	7,357	60,571	0	0	0	0	0	0	0	(365,187)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,793)	0	0	0	0	0	0	0	(4,793)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	200	0	0	0	0	0	0	0	0	200	24
25	Other Admin. Staff Transportation	0	0	529	0	0	0	0	0	0	0	0	529	25
26	Insurance-Prop.Liab.Malpractice	0	7,825	713	0	0	0	0	0	0	0	0	8,538	26
27	Other (specify):*	0	0	0	14,694	0	0	0	0	0	0	0	14,694	27
28	TOTAL General Administration	(462,351)	15,368	(103,479)	80,094	0	(470,368)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(463,467)	15,368	(100,182)	84,872	0	(463,409)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

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)	
	D. Ownership													
30	Depreciation	0	55,974	3,204	0	0	0	0	0	0	0	0	59,178	30
31	Amortization of Pre-Op. & Org.	(2,556)	2,556	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,491)	129,319	877	0	0	0	0	0	0	0	0	115,705	32
33	Real Estate Taxes	0	25,575	1,364	0	0	0	0	0	0	0	0	26,939	33
34	Rent-Facility & Grounds	0	(278,221)	0	0	0	0	0	0	0	0	0	(278,221)	34
35	Rent-Equipment & Vehicles	0	0	500	0	0	0	0	0	0	0	0	500	35
36	Other (specify):*	0	11,827	0	0	0	0	0	0	0	0	0	11,827	36
37	TOTAL Ownership	(17,047)	(52,970)	5,945	0	0	0	0	0	0	0	0	(64,072)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(150,411)	0	0	0	0	0	0	0	0	0	0	(150,411)	43
44	TOTAL Special Cost Centers	(150,411)	0	0	0	0	0	0	0	0	0	0	(150,411)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(630,925)	(37,602)	(94,237)	84,872	0	(677,892)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 278,221	Prairie Village Healthcare Center, LLC	100.00%	\$	\$ (278,221)	1
2	V	32 Interest	779	Prairie Village Healthcare Center, LLC	100.00%		(779)	2
3	V	19 Professional Fees		Prairie Village Healthcare Center, LLC	100.00%	7,250	7,250	3
4	V	21 Office		Prairie Village Healthcare Center, LLC	100.00%	293	293	4
5	V	26 Property Insurance		Prairie Village Healthcare Center, LLC	100.00%	7,825	7,825	5
6	V	30 Depreciation		Prairie Village Healthcare Center, LLC	100.00%	55,974	55,974	6
7	V	31 Amortization		Prairie Village Healthcare Center, LLC	100.00%	2,556	2,556	7
8	V	32 Interest		Prairie Village Healthcare Center, LLC	100.00%	130,098	130,098	8
9	V	33 Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	25,575	25,575	9
10	V	36 Mortgage Insurance Premium		Prairie Village Healthcare Center, LLC	100.00%	11,827	11,827	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 279,000			\$ 241,398	\$ * (37,602)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sherwin I. Ray	33.33%	Avenue Care Nursing and Rehab	Chicago, IL	Ext. Care Consult.	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ext. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			Snow Vally Nursing and Rehab	Lisle, IL				11
12			South Suburban Rehabilitation Center	Chicago, IL	Prairie Village			12
13			Tri-State Nursing and Rehab	Lansing, IL	Healthcare Ctr	Jacksonville, IL	Bldg. Company	13
14			Wheaton Care Center	Wheaton, IL				14
15			Boulevard Care Nursing and Rehab	Chicago, IL				15
16			Countryside Nursing and Rehab	Dolton, IL				16
17			Hillcrest Nursing and Rehab	Joliet, IL				17
18			Oak Park Healthcare Center	Oak Park, IL				18
19			Park House Nursing and Rehab	Chicago, IL				19
20			Timber Point Healthcare Center	Camp Point, IL				20
21			Prairie Village Healthcare Center	Jacksonville, IL				21
22			Dyer Nursing and Rehab	Dyer, IN				22
23			Lake County Nursing and Rehab	East Chicago, IN				23
24			Sebos Nursing and Rehab	Holbart, IN				24
25			Sheffield Manor Nursing Center	Indianapolis, IN				25
26			McKinley Health Care Center	Canton, OH				26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 149	\$	149	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	263		263	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	264		264	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	348		348	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,273		2,273	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,743		1,743	20
21	V	19 Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	4,422		(115,578)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,557		1,557	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	7,357		7,357	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	200		200	24
25	V	25 Other Staff Admin. Transportation		Extended Care Consulting, LLC	100.00%	529		529	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	713		713	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,204		3,204	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	877		877	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,364		1,364	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	500		500	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 120,000			\$ 25,763	\$ *	(94,237)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance	\$	Extended Care Consulting, LLC	100.00%	\$ 4,334	\$ 4,334	15
16	V	06 Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07 Emp. Ben. - Gen. Services		Extended Care Consulting, LLC	100.00%	444	444	17
18	V	07 Emp. Ben. - Gen. Services		Extended Care Consulting, LLC	100.00%			18
19	V	17 Administrative		Extended Care Consulting, LLC	100.00%	9,622	9,622	19
20	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	60,571	60,571	20
21	V	21 Office and Clerical	15,978	Extended Care Consulting, LLC	100.00%	15,978		21
22	V	27 Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC	100.00%	13,110	13,110	22
23	V	27 Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC	100.00%	1,584	1,584	23
24	V	22 Employee Benefits	4,793	Extended Care Consulting, LLC	100.00%		(4,793)	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		\$ 20,771			\$ 105,643	\$ * 84,872	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$	\$
16	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%		
18	V						
19	V						
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		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39 Ancillary	\$	Tricare Rehab	100.00%	\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 33,074	CCS VEBA	100.00%	\$ 33,074	\$	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		\$ 33,074			\$ 33,074	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0.00	See Attached	0.31	0.77%	Alloc. Salary	\$ 538	22 - 07	1
2	Sherwin Ray	Owner	Administration	33.33%	See Attached	4.68	11.70%	Salary	21,736	17 - 01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,274		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 Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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 Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,101,784	30	\$ 7,195	\$ 22,861	\$ 149	1
2	02	Food	Patient Days	1,101,784	30	12,684	22,861	263	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707	22,861	264	3
4	05	Utilities	Patient Days	1,101,784	30	16,778	22,861	348	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559	22,861	2,273	5
6	17	Administrative	Patient Days	1,101,784	30	84,000	22,861	1,743	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139	22,861	4,422	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016	22,861	1,557	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548	22,861	7,357	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615	22,861	200	10
11	25	Other Staff Admin. Transport.	Patient Days	1,101,784	30	25,510	22,861	529	11
12	26	Insurance	Patient Days	1,101,784	30	34,345	22,861	713	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393	22,861	3,204	13
14	32	Interest	Patient Days	1,101,784	30	42,261	22,861	877	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749	22,861	1,364	15
16	35	Rent - Equipment and Auto	Patient Days	1,101,784	30	24,117	22,861	500	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,241,616	\$	\$ 25,763	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9		
Schedule V 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	Patient Days	1,101,784	30	\$ 208,870	\$ 208,870	22,861	\$ 4,334	1
2	06	Maintenance	Direct	1	1			1		2
3	07	Emp. Ben. - Gen. Services	Patient Days	1,101,784	30	21,409	21,409	22,861	444	3
4	07	Emp. Ben. - Gen. Services	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,101,784	30	463,710	463,710	22,861	9,622	5
6	21	Office and Clerical	Patient Days	1,101,784	30	2,919,199	2,919,199	22,861	60,571	6
7	21	Office and Clerical	Direct	1	1	15,978	15,978	1	15,978	7
8	27	Emp. Ben. - Gen. Admin.	Patient Days	1,101,784	30	631,850	631,850	22,861	13,110	8
9	27	Emp. Ben. - Gen. Admin.	Direct	1	1	1,584		1	1,584	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					\$ 4,262,600	\$ 4,261,016		\$ 105,643	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Avenue #246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612 - 5662
 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	Dietary	Profit Margin %	122,604	23	\$ 88,277	\$	\$	1
2	10	Nursing	Profit Margin %	5,445	23	3,920			2
3	39	Ancillary	Profit Margin %	139,357	23	100,339			3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 192,536	\$	\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Tricare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, Illinois 60162
 Phone Number (708) 449 - 9400
 Fax Number (708) 449 - 9700

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	39	Ancillary	Profit Margin %	10,291,244	19	\$ 10,092,129		\$	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					\$ 10,092,129		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue, Suite 246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (847) 566 - 0800
 Fax Number ()

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	39	Ancillary	Profit Margin %	194,494	13	\$ 192,763		\$
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25	TOTALS					\$ 192,763		\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS VEBA
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V 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 Benefits	1	1	\$ 33,074	\$	1	\$ 33,074	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				\$ 33,074	\$		\$ 33,074	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Heartland Bank - HUD		X	Mortgage			\$	\$ 2,270,477			\$	130,098						
2																		
3																		
4																		
5																		
Working Capital																		
6	Care Consultants of Illinois		X									808						
7																		
8	Alloc. - Extended Care	X		Line of Credit								877						
9	TOTAL Facility Related						\$	\$ 2,270,477			\$	131,783						
B. Non-Facility Related*																		
10																		
11																		
12	Interest Income		X									(14,491)						
13	Interest Income - Bldg. Part.		X									(779)						
14	TOTAL Non-Facility Related						\$	\$			\$	(15,270)						
15	TOTALS (line 9+line14)						\$	\$ 2,270,477			\$	116,513						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,827 Line # 36

* 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.)

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-17-100-012</u>	<u>Long Term Care Facility</u>	\$ <u>23,575.36</u>	\$ <u>23,575.36</u>
2. <u>Allocation</u>	<u>Long Term Care Facility</u>	\$ <u>133,178.74</u>	\$ <u>1,116.99</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>156,754.10</u></u>	\$ <u><u>24,692.35</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>8,686</u>	<u>1997</u>	<u>\$ 170,000</u>	1
2	<u>Alloc. Extended Care</u>			<u>6,622</u>	2
3	TOTALS	8,686		\$ 176,622	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	126	1997		\$ 1,114,539	\$ 28,577	39	\$ 28,577		\$ 470,360	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Prairie Village Healthcare Center (Operating Entity)									
10	Various		2002	4,490	265	27.5	265		3,047	9
11	Various		2003	13,083	577	15 - 27.5	577		6,055	10
12	Various		2004	5,343	190	27.5	190		1,916	11
13	Various		2005	4,475	298	15	298		2,535	12
14	Various		2006	13,021	523	15 - 27.5	523		3,878	13
15	Various		2007	7,421	389	15 - 27.5	389		2,491	14
16	Various		2009	11,377	494	5 - 27.5	494		3,243	15
17	Fire Supression		2010	4,857	177	27.5	177		684	16
18	Bathroom Flooring		2010	2,750	100	27.5	100		388	17
19	Phone System		2011	5,707	208	10	208		519	18
20	Outside Patio		2011	3,725	135	15	135		293	19
21	Doors		2012	8,460	308	27.5	308		425	20
22	Stool Repair		2012	6,824	248	27.5	248		414	21
23	Fire Protection Engineering		2012	10,500	382	27.5	382		541	22
24										23
25										24
26										25
27	Prairie Village Healthcare Center, LLC (Building Partnership)									
28	Various		1997	487,113	12,470	39	12,470		201,968	26
29	Various		1998	185,832	4,784	39	4,784		74,623	27
30	Various		1999	3,549	91	39	91		1,278	28
31	Various		2000	9,164	333	27.5	333		4,435	29
32	Various		2001	54,531	1,983	27.5	1,983		25,327	30
33	Various		2008	134,167	5,056	15 - 27.5	5,056		26,405	31
34	Windows		2009	63,595	2,313	27.5	2,313		10,503	32
35	Concrete Pad for Bathroom		2010	14,295	367	39	367		1,359	33
36										34
										35
										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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	2,168,818	\$	60,268	\$	60,268	\$	842,687	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,168,818	\$ 60,268		\$ 60,268	\$	\$ 842,687	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5									5
6	Allocations - Extended Care Consulting	2007	95	5	5			33	6
7	Allocations - Extended Care Consulting	2009	57	3	3			14	7
8	Allocations - Extended Care Consulting	2010	560	28	28			112	8
9	Allocations - Extended Care Consulting	2011	201	10	10			30	9
10	Allocations - Extended Care Consulting	2012	66	3	3			7	10
11									11
12									12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2002	9,126	234	234			2,642	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2002	7,539	689	689			6,896	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2003	8,884	812	812			8,127	15
16	Allocations - Extended Care Consulting / 2201 Main LLC	2005	441	47	47			347	16
17	Allocations - Extended Care Consulting / 2201 Main LLC	2009	80	4	4			20	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)		\$ 2,195,867	\$ 62,103		\$ 62,103	\$	\$ 860,915	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 209,483	\$ 1,033	\$ 1,033	\$	5 - 7	\$ 191,118	71
72	Current Year Purchases					5 - 7		72
73	Fully Depreciated Assets							73
74	See Supplemental	155,121	1,369	1,369			153,642	74
75	TOTALS	\$ 364,604	\$ 2,402	\$ 2,402	\$		\$ 344,760	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Alloc. - Extended Care			3,216					3,216	77
78										78
79										79
80	TOTALS			\$ 3,216	\$	\$	\$		\$ 3,216	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)	\$ 2,740,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,505	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,208,891	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

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Prairie Village Healthcare Center, LLC			
Prior	69,000		69,000
Current			
Total	69,000	-	69,000
Related Party 2 - Extended Care Consulting, LLC			
Prior	60,957	215	59,847
Current	410	41	41
Total	61,367	256	59,888
Related Party 3 - Extended Care Consulting, LLC / 2201 Main LLC			
Prior	2,527	29	2,527
Current			
Total	2,527	29	2,527
Related Party 4 - Vent Lease - Matrix Software			
Prior	22,227	1,084	22,227
Current			
Total	22,227	1,084	22,227
Total	155,121	1,369	153,642

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

N/A - Related Party

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See							5
6	Supplement				695			6
7	TOTAL				\$ 695			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: \$ 13,013

Description: See Supplemental 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	Facility	Ford	\$	\$ 3,321	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,321	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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
AB&C Mini Storage	695
Total	<u>695</u>

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Digital Copy System	2,520
Flynn Sales Services	8,125
Pitney Bowes	488
Quality Water Solution	1,380
Alloc. - Extended Care Consulting	500
Total	<u>13,013</u>

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	205,534	\$		\$	205,534	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					19,356				19,356	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs					158,787				158,787	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 prescripts						142,692			142,692	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify): <u>See Supplemental</u>	39 - 02							27,451			27,451	12
13	Other (specify): <u>See Supplemental</u>	39 - 03							67,374			67,374	13
14	TOTAL			\$			\$	451,051	\$	170,143	\$	621,194	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

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen	25,288	
Medical Supplies	1,336	
Therapy and Rehab Supplies	686	
Prosthetics and Orthotics	38	
Food Pump and Supplies	103	
Ambulance		36,068
Laboratory		11,928
Radiology		12,089
Ventilation Therapy		424
Other		6,865
Total	27,451	67,374

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(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	\$	\$ 47	1
2	Cash-Patient Deposits	31,463	31,463	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>553,356</u>)	1,068,768	1,068,768	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,893	36,893	6
7	Other Prepaid Expenses	23,495	23,495	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	97	97	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,160,716	\$ 1,160,763	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,114,539	14
15	Leasehold Improvements, at Historical Cost	105,596	1,057,842	15
16	Equipment, at Historical Cost	205,920	274,920	16
17	Accumulated Depreciation (book methods)	(230,665)	(1,115,922)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	282,048	1,759,873	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 362,899	\$ 3,261,252	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,523,615	\$ 4,422,015	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 822,478	\$ 1,047,178	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,216	25,216	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,497	90,497	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,048	4,048	31
32	Accrued Real Estate Taxes(Sch.IX-B)		24,800	32
33	Accrued Interest Payable		10,709	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	711,266	1,065,673	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,653,505	\$ 2,268,121	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,336,487	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,336,487	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,653,505	\$ 4,604,608	46
47	TOTAL EQUITY(page 18, line 24)	\$ (129,890)	\$ (182,593)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,523,615	\$ 4,422,015	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due From Employees	97	97
Total	97	97
Line 23 - Other Long Term Assets		
State Replacement Tax Benefit	200	200
Construction in Progress	281,848	1,059,548
Escrow Reserves		649,328
Financing Costs (Net of Amortization)		50,797
Total	282,048	1,759,873
Line 36 - Other Current Liabilities		
Due to Related Parties	711,266	1,065,673
Total	711,266	1,065,673
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 670,830	1
2	Restatements (describe):		2
3	PY Distributions Not Recorded in FY 12/31/12 Cost Report	(500,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 170,830	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(300,720)	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)	\$ (300,720)	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)	\$ (129,890)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,056,215	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,056,215	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,579	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 122,579	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,491	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,491	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	75,463	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 75,463	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,268,748	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	722,367	31
32	Health Care	1,277,306	32
33	General Administration	1,306,458	33
B. Capital Expense			
34	Ownership	300,885	34
C. Ancillary Expense			
35	Special Cost Centers	771,605	35
36	Provider Participation Fee	190,847	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,569,468	40
41	Income before Income Taxes (line 30 minus line 40)**	(300,720)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (300,720)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,437,892	44
45	Private Pay - Net Inpatient Revenue	127,175	45
46	Medicare - Net Inpatient Revenue	1,395,526	46
47	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	95,622	47
48	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,056,215	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	2,011	2,169	\$ 71,548	\$ 32.99	1
2	Assistant Director of Nursing	1,900	2,103	47,437	22.56	2
3	Registered Nurses	5,315	5,943	147,332	24.79	3
4	Licensed Practical Nurses	18,340	20,045	379,742	18.94	4
5	CNAs & Orderlies	39,065	41,660	410,605	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,798	1,906	19,886	10.43	8
9	Activity Director	1,816	1,952	21,640	11.09	9
10	Activity Assistants	2,276	2,425	21,040	8.68	10
11	Social Service Workers	2,557	2,974	52,397	17.62	11
12	Dietician					12
13	Food Service Supervisor	1,963	2,163	33,005	15.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,954	4,435	40,744	9.19	15
16	Dishwashers	8,041	8,800	74,865	8.51	16
17	Maintenance Workers	5,817	6,321	73,591	11.64	17
18	Housekeepers	9,970	10,917	92,682	8.49	18
19	Laundry	4,281	4,662	40,172	8.62	19
20	Administrator	1,874	2,069	77,603	37.51	20
21	Assistant Administrator					21
22	Other Administrative	241	243	21,736	89.45	22
23	Office Manager					23
24	Clerical	3,020	3,381	70,895	20.97	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	1,640	1,823	19,728	10.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Non-Allowable</u>	2,085	2,085	150,411	72.14	33
34	TOTAL (lines 1 - 33)	117,964	128,076	\$ 1,867,059 *	\$ 14.58	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 7,306	01 - 03	35
36	Medical Director	18,000	09 - 03	36
37	Medical Records Consultant	451	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,624	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	5,751	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 36,132		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kelly K. Rothering	Administrator	0	\$ 77,603	Workers' Compensation Insurance	\$ 70,865	IDPH License Fee	\$ 1,990	
Sherwin Ray	Administration	33.33%	21,736	Unemployment Compensation Insurance	43,232	Advertising: Employee Recruitment	6,582	
				FICA Taxes	139,147	Health Care Worker Background Check	404	
				Employee Health Insurance	21,874	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	443	
				Employee Physicals	865	Licenses	1,155	
				Holiday Expense	1,250	Advertising and Promotion	10,950	
				Other Employee Welfare	3,454	Alloc. Extended Care Consulting, LLC	1,557	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,339					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Extended Care Consulting, LLC	Home Office		\$ 120,000			\$	Out-of-State Travel	\$
Personnel Planners, Inc.	Unemployment Consultant		1,433					
Plante & Moran, PLLC	Accounting		20,350					
Frost, Ruttenberg & Rothblatt	Accounting		1,500				In-State Travel	
Krupnick, Bokor, & Kagda	Accounting		1,795					
Singer Networks	Computer Maintenance		9,059					
ProPay Payroll Services	Data Processing		11,572				Seminar Expense	1,067
Medifax	Data Processing		859				Alloc. Extended Care Consulting, LLC	200
E-Health Data Solutions	Data Processing		4,785					
American Data	Data Processing		5,054					
Nebo Systems	Data Processing		72					
See Supplemental Schedule			35,871				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 212,350	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,267

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
MDI Achieve	Data Processing	4,754
Ability Network	Data Processing	1,933
Natinoal Datacare Corporation	Data Processing	1,922
Kelly Rothering	Data Processing	147
Burke, Warren, MacKay & Serritella, P.C.	Legal	4,297
Daniel Mahel Law Offices	Legal	434
Williams Montgomery & John, Ltd.	Legal	6,086
Meyer Magence	Legal	375
Robbins, Saoloman & Patt, Ltd.	Legal	613
HFG	Other	7,106
Blymas	Other	5,679
Care Consultants of Illinois	Other	45
CORI	Other	80
Pharmacy Price Management	Other	1,727
Resolution Systems	Other	223
Katherine Aubry	Other	450

Total

35,871

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Burke, Warren, MacKay & Serritella, P.C.		244	
Daniel Mahel Law Offices		260	
Daniel Mahel Law Offices		60	
Burke, Warren, MacKay & Serritella, P.C.		186	
Burke, Warren, MacKay & Serritella, P.C.		328	
Burke, Warren, MacKay & Serritella, P.C.		209	
Williams Montgomery & John, Ltd.		350	
Burke, Warren, MacKay & Serritella, P.C.		241	
Williams Montgomery & John, Ltd.		335	
Meyer Magence		375	375
Burke, Warren, MacKay & Serritella, P.C.		427	
Burke, Warren, MacKay & Serritella, P.C.		280	
Daniel Mahel Law Offices		60	60
Daniel Mahel Law Offices		54	54
Williams Montgomery & John, Ltd.		928	
Burke, Warren, MacKay & Serritella, P.C.		415	
Williams Montgomery & John, Ltd.		1,058	
Burke, Warren, MacKay & Serritella, P.C.		699	
Burke, Warren, MacKay & Serritella, P.C.		166	
Williams Montgomery & John, Ltd.		3,154	
Robbins, Saoloman & Patt, Ltd.		613	613
Burke, Warren, MacKay & Serritella, P.C.		802	
Burke, Warren, MacKay & Serritella, P.C.		300	
Williams Montgomery & John, Ltd.		261	
Total		11,805	1,102
Non-Allowable			10,703

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10 - 02
- (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. \$ 190,847
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? Ln. 14
 - 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? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees