



Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	471		682	1,153	8
9	SNF/PED					9
10	ICF	19,085	1,936	2,004	23,025	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,556	1,936	2,686	24,178	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.91%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 50 and days of care provided 682

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name &amp; ID Number

Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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
	<b>A. General Services</b>										
1	Dietary	124,955	16,865	6,718	148,538		148,538		148,538		1
2	Food Purchase		133,668		133,668		133,668	(57)	133,611		2
3	Housekeeping	112,230	22,064		134,294		134,294	81	134,375		3
4	Laundry	54,587	18,968		73,555		73,555		73,555		4
5	Heat and Other Utilities			60,828	60,828		60,828	577	61,405		5
6	Maintenance	41,336	35,873	45,483	122,692		122,692	(57,089)	65,603		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	333,108	227,438	113,029	673,575		673,575	(56,488)	617,087		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,088,729	29,151	7,757	1,125,637		1,125,637	20,881	1,146,518		10
10a	Therapy	15,555	4,126		19,681		19,681		19,681		10a
11	Activities	57,287	3,354		60,641		60,641		60,641		11
12	Social Services	70,170		11,430	81,600		81,600		81,600		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,283	3,283		15
16	<b>TOTAL Health Care and Programs</b>	1,231,741	36,631	26,387	1,294,759		1,294,759	24,164	1,318,923		16
	<b>C. General Administration</b>										
17	Administrative	86,497			86,497		86,497	48,848	135,345		17
18	Directors Fees										18
19	Professional Services			417,774	417,774	(1,301)	416,473	(314,813)	101,660		19
20	Dues, Fees, Subscriptions & Promotions			20,257	20,257		20,257	(7,554)	12,703		20
21	Clerical & General Office Expenses	41,834	3,510	386,577	431,921		431,921	(245,457)	186,464		21
22	Employee Benefits & Payroll Taxes			257,516	257,516		257,516		257,516		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,003	5,003		5,003	56	5,059		24
25	Other Admin. Staff Transportation			22,504	22,504		22,504	5,153	27,657		25
26	Insurance-Prop.Liab.Malpractice			54,932	54,932		54,932	2,028	56,960		26
27	Other (specify):*							23,793	23,793		27
28	<b>TOTAL General Administration</b>	128,331	3,510	1,164,563	1,296,404	(1,301)	1,295,103	(487,946)	807,157		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,693,180	267,579	1,303,979	3,264,738	(1,301)	3,263,437	(520,270)	2,743,167		29

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

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

Facility Name &amp; ID Number

Prairie View Cr Ctr Lewistwn

#0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			27,137	27,137		27,137	123,024	150,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,931	13,931		13,931	94,081	108,012			32
33	Real Estate Taxes			16,488	16,488	1,301	17,789	5,435	23,224			33
34	Rent-Facility & Grounds			48,625	48,625		48,625	(42,831)	5,794			34
35	Rent-Equipment & Vehicles			7,062	7,062		7,062	3,757	10,819			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			113,243	113,243	1,301	114,544	183,466	298,010			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,878	77,269	238,147		238,147		238,147			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,289	209,289		209,289		209,289			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		160,878	286,558	447,436		447,436		447,436			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,693,180	428,457	1,703,780	3,825,417		3,825,417	(336,804)	3,488,613			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(1,536)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	48,485	30		9
10	Interest and Other Investment Income	(70)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(107)	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	(266,445)	21		18
19	Entertainment				19
20	Contributions	(1,000)	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	(52,575)	21		24
25	Fund Raising, Advertising and Promotional	(8,707)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(892)	20		28
29	Other-Attach Schedule	(78,175)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (361,022)		\$	30

<b>BHF USE ONLY</b>						
48		49		50		51
						52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	24,218		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 24,218		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (336,804)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Prairie View Cr Ctr Lewistwn

Report Period Beginning: ID# 0040303  
 Ending: 01/01/14  
 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalize R & M	\$ (61,223)	06	1
2	Bank Charges	(11,987)	21	2
3	Non-Allowable Seminar Expense	(209)	24	3
4	Additional R&M	4,768	06	4
5	Non-Allowable Legal	(1,192)	19	5
6	State Replacement Tax	(3,000)	21	6
7	Miscellaneous Income	(1,489)	21	7
8				8
9				9
10	Building Co			10
11	Accounting Fees	(1,480)	19	11
12	Management Fees	(565)	19	12
13	Amortization	(1,798)	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	<b>Total</b>		(78,175)	49

Prairie View Cr Ctr Lewistwn

ID# 0040303

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie View Cr Ctr Lewistwn# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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
2	Food Purchase	(107)		50									(57)	2
3	Housekeeping			81									81	3
4	Laundry													4
5	Heat and Other Utilities			577									577	5
6	Maintenance	(57,991)		902									(57,089)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(58,098)</b>		<b>1,610</b>									<b>(56,488)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			20,881									20,881	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,283									3,283	15
16	<b>TOTAL Health Care and Programs</b>			<b>24,164</b>									<b>24,164</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative		565	48,283									48,848	17
18	Directors Fees													18
19	Professional Services	(3,237)	1,480	(313,056)									(314,813)	19
20	Fees, Subscriptions & Promotions	(10,599)		3,045									(7,554)	20
21	Clerical & General Office Expenses	(335,496)		90,039									(245,457)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(209)		265									56	24
25	Other Admin. Staff Transportation			5,153									5,153	25
26	Insurance-Prop.Liab.Malpractice			2,028									2,028	26
27	Other (specify):*			23,793									23,793	27
28	<b>TOTAL General Administration</b>	<b>(349,541)</b>	<b>2,045</b>	<b>(140,450)</b>									<b>(487,946)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(407,639)</b>	<b>2,045</b>	<b>(114,676)</b>									<b>(520,270)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	48,485	68,549	5,990									123,024	30
31	Amortization of Pre-Op. & Org.	(1,798)	1,798											31
32	Interest	(70)	94,144	7									94,081	32
33	Real Estate Taxes		5,435										5,435	33
34	Rent-Facility & Grounds		(48,000)	5,169									(42,831)	34
35	Rent-Equipment & Vehicles			3,757									3,757	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>46,617</b>	<b>121,926</b>	<b>14,923</b>									<b>183,466</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(361,022)</b>	<b>123,971</b>	<b>(99,753)</b>									<b>(336,804)</b>	<b>45</b>

**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 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 48,000	Prairie View Care Center of Lewistown, LLC	100.00%	\$	\$ (48,000)	1
2	V	33 Real Estate Income	16,488	Prairie View Care Center of Lewistown, LLC	100.00%		(16,488)	2
3	V	33 Real Estate Tax Expense		Prairie View Care Center of Lewistown, LLC	100.00%	21,923	21,923	3
4	V	30 Depreciation		Prairie View Care Center of Lewistown, LLC	100.00%	68,549	68,549	4
5	V	32 Interest		Prairie View Care Center of Lewistown, LLC	100.00%	94,144	94,144	5
6	V	19 Accounting		Prairie View Care Center of Lewistown, LLC	100.00%	1,480	1,480	6
7	V	17 Management Fees		Prairie View Care Center of Lewistown, LLC	100.00%	565	565	7
8	V	31 Amortization		Prairie View Care Center of Lewistown, LLC	100.00%	1,798	1,798	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 64,488			\$ 188,459	\$ * 123,971	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	2 FOOD	\$	CERTIFIED HEALTH MANAGEMENT	100.00%	\$ 50	\$	50	15
16	V	3 HOUSEKEEPING		CERTIFIED HEALTH MANAGEMENT	100.00%	81		81	16
17	V	5 UTILITIES		CERTIFIED HEALTH MANAGEMENT	100.00%	577		577	17
18	V	6 REPAIRS AND MAINTENANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	902		902	18
19	V	10 NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	20,881		20,881	19
20	V	15 EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	3,283		3,283	20
21	V	17 ADMINISTRATIVE SALARIES		CERTIFIED HEALTH MANAGEMENT	100.00%	19,566		19,566	21
22	V	19 PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	22,790		22,790	22
23	V	20 DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	3,045		3,045	23
24	V	21 SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	74,235		74,235	24
25	V	21 OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	15,804		15,804	25
26	V	24 SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	265		265	26
27	V	25 AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	5,153		5,153	27
28	V	26 INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	2,028		2,028	28
29	V	27 EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	17,856		17,856	29
30	V	30 DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	5,990		5,990	30
31	V	32 INTEREST		CERTIFIED HEALTH MANAGEMENT	100.00%	7		7	31
32	V	34 RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	5,169		5,169	32
33	V	35 EQUIPMENT RENTAL		CERTIFIED HEALTH MANAGEMENT	100.00%	425		425	33
34	V	35 AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	3,332		3,332	34
35	V								35
36	V	17 ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	28,717		28,717	36
37	V	27 EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	5,937		5,937	37
38	V	19 HOME OFFICE EXPENSE	335,846	CERTIFIED HEALTH MANAGEMENT	100.00%			(335,846)	38
39	Total		\$ 335,846			\$ 236,093	\$ *	(99,753)	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BRADLEY ALTER & BETH ALTER	37.085	DANVILLE CARE CENTER, LTD.	DANVILLE	PRAIRIE VIEW CARE CENTER	SKOKIE	REAL ESTATE	1
2	HOWARD A. GELLER & RITA GELLER	47.417%	GLENWOOD HEALTHCARE & REHAB, INC.	GLENWOOD	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	MR. LAURENCE ZUNG	3.506%	RENAISSANCE CARE CENTER, INC.	CANTON				3
4	MRS. IRENE SANDLER	2.768%	PAXTON HEALTHCARE AND REHAB	PAXTON				4
5	MR. IRA SHYMAN	1.845%	PONTIAC HEALTHCARE AND REHAB	PONTIAC				5
6	MR. JOSEPH L ASHMAN	1.845%						6
7	RABBI MORRIS NOBLE	1.845%						7
8	JENNIFER CHOW	1.845%						8
9	JULIE BRUM	1.845%						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

Facility Name & ID Number

Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 01/01/14 Ending: 12/31/14

## 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	Bradley Alter	Owner	Administration	37.09%	See Attached	7.18	14.36%	Alloc Salary	\$ 28,717	17-7	1
2	Daniel Alter	Relative	Financial	0.00%	See Attached	5.03	14.37%	Alloc Salary	3,406	21-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 32,123		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization CERTIFIED HEALTH MANAGEMENT  
 Street Address 3856 W. OAKTON  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	2	FOOD	PATIENT DAYS	168,387	6	\$ 349	24,178	\$ 50	1	
2	3	HOUSEKEEPING	PATIENT DAYS	168,387	6	566	24,178	81	2	
3	5	UTILITIES	PATIENT DAYS	168,387	6	4,022	24,178	577	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	168,387	6	6,283	24,178	902	4	
5	10	NURSING	PATIENT DAYS	168,387	6	145,423	145,423	20,881	5	
6	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	168,387	6	22,862	24,178	3,283	6	
7	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	168,387	6	136,269	136,269	19,566	7	
8	19	PROFESSIONAL FEES	PATIENT DAYS	168,387	6	158,722	24,178	22,790	8	
9	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	168,387	6	21,206	24,178	3,045	9	
10	21	SALARIES - CLERICAL	PATIENT DAYS	168,387	6	517,009	517,009	74,235	10	
11	21	OFFICE EXPENSES	PATIENT DAYS	168,387	6	110,068	24,178	15,804	11	
12	24	SEMINAR EXPENSE	PATIENT DAYS	168,387	6	1,845	24,178	265	12	
13	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	168,387	6	35,887	24,178	5,153	13	
14	26	INSURANCE	PATIENT DAYS	168,387	6	14,124	24,178	2,028	14	
15	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	168,387	6	124,361	24,178	17,856	15	
16	30	DEPRECIATION	PATIENT DAYS	168,387	6	41,720	24,178	5,990	16	
17	32	INTEREST	PATIENT DAYS	168,387	6	49	24,178	7	17	
18	34	RENT	PATIENT DAYS	168,387	6	36,000	24,178	5,169	18	
19	35	EQUIPMENT RENTAL	PATIENT DAYS	168,387	6	2,961	24,178	425	19	
20	35	AUTO LEASE	PATIENT DAYS	168,387	6	23,207	24,178	3,332	20	
21									21	
22	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKI	50	6	200,000	200,000	7.18	28,717	22
23	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKI	50	6	41,351		7.18	5,937	23
24									24	
25	TOTALS					\$ 1,644,284	\$ 998,701	\$ 236,093	25	

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

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 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	
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7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	
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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	
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2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

**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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Enloe		X				\$	\$ 16,497			\$ 1,795	1					
2	Renaissance Care Center, LLC	X		Mortgage	\$7,319.55	09/03/09		3,028,781	09/01/2015	2.9000	87,834	2					
3	Mortgage		X	Mortgage				497,540			6,309	3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Insurance Financing		X								2,075	6					
7	Bank Financial		X	Working Capital				267,943			10,061	7					
8	See Supplemental Schedule										7	8					
9	<b>TOTAL Facility Related</b>				\$7,319.55		\$ 3,028,781	\$ 781,980			\$ 108,081	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(70)	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (70)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 3,028,781	\$ 781,980			\$ 108,011	15					

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

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

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

Facility Name & ID Number

Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8							\$	\$			\$					
9	<b>Allocated from Certified</b>		X								7					
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>										7					
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<b>28,033</b>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>21,923</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(6,110)</b>		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>28,035</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>1,301</b>		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>23,226</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>23,917</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>24,879</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>25,884</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>25,966</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>21,923</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>2014 Accrual: \$21,923 x 1.28 = \$28,035</b>					

**NOTES:**

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

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie View Cr Ctr Lewistwn COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0040303

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-19-27-141-004</u>	<u>Long Term Care Property</u>	\$ <u>21,923.00</u>	\$ <u>21,923.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>21,923.00</u></u>	\$ <u><u>21,923.00</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?                 YES        X   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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <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?             YES             NO

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

**C. Tax Bills**

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

**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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>			\$ <u>148,500</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>148,500</b>	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1976	\$ 2,673,000	\$ 68,549	27.5	\$ 97,200	\$ 28,651	\$ 1,368,814	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1993	26,538		20			26,538	9
10	Various		1994	16,141		20	128	128	16,141	10
11	Various		1995	1,113		20	56	56	1,083	11
12	Various		1997	16,918		20	846	846	14,768	12
13	Various		1998	21,440		20	1,072	1,072	17,643	13
14	Various		1999	21,882		20	1,094	1,094	16,913	14
15	Various		2000	8,158		20	375	375	5,982	15
16	Various		2001	13,060		20	612	612	9,319	16
17	Various		2002	1,750		20	88	88	1,094	17
18	Various		2003	12,425		20	621	621	7,036	18
19	Various		2004	13,699		20	685	685	7,192	19
20	Various		2005	9,041		20	452	452	4,382	20
21	Various		2006	20,000		20	1,000	1,000	8,500	21
22	Various		2007	15,599		20	780	780	6,006	22
23	Various		2008	33,122		20	2,946	2,946	19,424	23
24	Various		2009	11,024		20	381	381	5,341	24
25	Various		2010	27,572		20	1,379	1,379	6,875	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			17,333	4,151	771	(3,380)	12,271	68
69				27,137		(27,137)		69
70			\$ 2,959,815	\$ 99,837		\$ 110,485	\$ 10,648	\$ 1,555,321 70

\*\*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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,959,815	\$ 99,837		\$ 110,485	\$ 10,648	\$ 1,555,321	1
2	Shingles	2011	2,650		20	133	133	453	2
3	Water Heater	2012	3,310		20	166	166	497	3
4	Telephone System	2012	2,293		20	459	459	1,261	4
5	A/C Compressor	2012	4,261		20	213	213	550	5
6	Rooftop Hvac Units	2012	10,630		20	532	532	1,284	6
7	Video Monitor System	2012	8,043		20	1,149	1,149	3,255	7
8	Security Systems	2013	3,017		20	431	431	826	8
9	Alarm System Installation, Wiring, Connectors - Whole House	2013	7,566		20	378	378	694	9
10	Landscaping Phase 1 And Phase 2	2013	6,025		20	402	402	536	10
11	Ellsworth Glass & Aluminum - Windows	2013	3,043		20	152	152	216	11
12	Carpet Tile And Cornices - Dining Room	2013	3,978		20	199	199	298	12
13	New Ceiling & Wall, Ceiling Repairs - Room 301	2013	2,800		20	140	140	210	13
14	Heat Exchanger For Laundry	2014	3,852		20	257	257	257	14
15	Plaster Repairs	2014	2,795		20	23	23	23	15
16	New Alarm/Camera/Monitoring System	2014	3,259		20	163	163	163	16
17	Firewall Upgrade In Three Area	2014	2,500		20	125	125	125	17
18	Roof Repairs	2014	9,500		20	475	475	475	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,039,337	\$ 99,837		\$ 115,880	\$ 16,043	\$ 1,566,444	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,039,337	\$ 99,837		\$ 115,880	\$ 16,043	\$ 1,566,444	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)		\$ 3,039,337	\$ 99,837		\$ 115,880	\$ 16,043	\$ 1,566,444	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>3,039,337</b>	\$ <b>99,837</b>		\$ <b>115,880</b>	\$ <b>16,043</b>	\$ <b>1,566,444</b>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,039,337</b>	\$ <b>99,837</b>		\$ <b>115,880</b>	\$ <b>16,043</b>	\$ <b>1,566,444</b>	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,039,337	\$ 99,837		\$ 115,880	\$ 16,043	\$ 1,566,444	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)		\$ 3,039,337	\$ 99,837		\$ 115,880	\$ 16,043	\$ 1,566,444	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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									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									34
	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<b>Allocated from Certified Health Management</b>	1997	13,529	347	20	676	329	12,176	9
10	<b>Allocated from Certified Health Management</b>	2014	3,804	3,804	20	95	(3,709)	95	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,333	\$ 4,151		\$ 771	\$ (3,380)	\$ 12,271	34

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 17,333	\$ 4,151		\$ 771	\$ (3,380)	\$ 12,271	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)		\$ 17,333	\$ 4,151		\$ 771	\$ (3,380)	\$ 12,271	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 151,568	\$ 580	\$ 25,458	\$ 24,878	10	\$ 88,650	71
72	Current Year Purchases	90,756	1,260	7,921	6,661	10	7,921	72
73	Fully Depreciated Assets	299,552		443	443	10	299,552	73
74								74
75	TOTALS	\$ 541,877	\$ 1,840	\$ 33,821	\$ 31,981		\$ 396,122	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		VEHICLES	1996	\$ 4,476	\$	\$	\$	5	\$ 4,476	76
77		VEHICLES	1999	20,436				5	20,436	77
78		Auto Expense	2014	3,332		460	460	5	460	78
79										79
80	TOTALS			\$ 28,244	\$	\$ 460	\$ 460		\$ 25,372	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,757,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,677	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,162	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,485	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,987,938	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.

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A/

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Rental				625			5
6	Allocated from Certified Health Management				5,169			6
7	TOTAL				\$ 5,794			7

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. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \$ 5,187

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Certified Health Mgmnt		\$	\$ 3,332	17
18	Facility Auto Expense			2,300	18
19					19
20					20
21	TOTAL		\$	\$ 5,632	21

\* 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.

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

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

	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	\$		\$	41,878	\$		\$	41,878	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				14,460				14,460	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				20,931				20,931	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					27,381			27,381	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>							133,497			133,497	13
14	TOTAL			\$		\$	77,269	\$	160,878	\$	238,147	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.

Facility Name & ID Number Prairie View Cr Ctr Lewistwn# 0040303Report Period Beginning: 01/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 38,359	\$ 233,759	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,139,999	1,139,999	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,002	44,002	6
7	Other Prepaid Expenses	9,501	9,501	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		78,565	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,231,861	\$ 1,505,826	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		164,433	13
14	Buildings, at Historical Cost		2,736,731	14
15	Leasehold Improvements, at Historical Cost	323,856	323,856	15
16	Equipment, at Historical Cost	358,628	507,128	16
17	Accumulated Depreciation (book methods)	(435,930)	(1,580,502)	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):	28,987	88,020	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 275,541	\$ 2,239,666	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,507,402	\$ 3,745,492	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 463,289	\$ 871,417	26
27	Officer's Accounts Payable	526,709	526,709	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	284,440	284,440	29
30	Accrued Salaries Payable	104,530	104,530	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,657	9,657	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,035	28,035	32
33	Accrued Interest Payable	94,093	554,643	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	265,110	265,110	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,775,863	\$ 2,644,541	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		497,540	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule	2,509,325	4,471,104	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,509,325	\$ 4,968,644	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,285,188	\$ 7,613,185	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,777,786)	\$ (3,867,693)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,507,402	\$ 3,745,492	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,834,626)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,834,626)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	56,840	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>56,840</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,777,786)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 3,562,426	1	
2	Discounts and Allowances for all Levels	182,105	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,744,531	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	59,825	6	
7	Oxygen	1,054	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 60,879	8	
<b>C. Other Operating Revenue</b>				
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	4,385	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	1,071	19	
20	Radiology and X-Ray	231	20	
21	Other Medical Services	3,826	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,513	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	70	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 70	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>See Supplemental Schedule</u>	67,264	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 67,264	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,882,257	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	673,575	31	
32	Health Care	1,294,759	32	
33	General Administration	1,296,404	33	
<b>B. Capital Expense</b>				
34	Ownership	113,243	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	238,147	35	
36	Provider Participation Fee	209,289	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,825,417	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	56,840	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 56,840	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,847,148	44
45	Private Pay - Net Inpatient Revenue	279,806	45
46	Medicare - Net Inpatient Revenue	289,383	46
47	Other-(specify) <u>Managed Care</u>	73,594	47
48	Other-(specify) <u>Hospice</u>	254,600	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,744,531	49

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

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

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

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn

# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	1,568	1,858	\$ 61,387	\$ 33.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,072	9,159	233,000	25.44	3
4	Licensed Practical Nurses	12,760	13,001	281,977	21.69	4
5	CNAs & Orderlies	40,685	43,257	482,006	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,493	1,493	15,555	10.42	8
9	Activity Director	1,520	1,521	23,179	15.24	9
10	Activity Assistants	2,555	2,557	34,108	13.34	10
11	Social Service Workers	4,725	4,835	70,170	14.51	11
12	Dietician					12
13	Food Service Supervisor	1,536	1,537	30,221	19.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,164	10,204	94,734	9.28	15
16	Dishwashers					16
17	Maintenance Workers	3,548	3,555	41,336	11.63	17
18	Housekeepers	9,741	9,841	112,230	11.40	18
19	Laundry	4,930	4,960	54,587	11.01	19
20	Administrator	1,809	1,814	86,497	47.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,772	2,780	41,834	15.05	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	1,728	1,732	30,359	17.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,606	114,104	\$ 1,693,180 *	\$ 14.84	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	168	\$ 6,718	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	32	1,564	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	95	6,193	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	58	6,030	12-03	45
46	Other(specify)				46
47	Psychosocial Consulting	56	5,400	12-03	47
48					48
49	TOTAL (lines 35 - 48)	409	\$ 33,105		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

**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	
Roger Herman	Administrator	0	\$ 86,497	Workers' Compensation Insurance	\$ 48,878	IDPH License Fee	\$	
				Unemployment Compensation Insurance	23,602	Advertising: Employee Recruitment		
				FICA Taxes	127,823	Health Care Worker Background Check		
				Employee Health Insurance	52,495	(Indicate # of checks performed <u>62</u> )	625	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	669	
				Pension Plan	4,717	Employee Hiring Costs	3,417	
						Licenses and Permits	4,947	
						Allocated from Certified Health Mgmt	3,045	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 86,497					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 257,515	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				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	
Wescom	Data Processing	12,513			\$	Out-of-State Travel	\$	
See attached	Legal Fees	27,674						
Richard Peelo	Accounting Services	3,750				In-State Travel		
Paychex	Payroll Services	9,622						
Ehealth	MDS Software	3,894						
Hamlin & Burton	Liability Management	429				Seminar Expense	4,794	
John Bernadyn	Professional Fees	3,150				Allocate from Certified Health Mgmt	265	
MPRO	Conflict Resolution	7,385						
Neal Transcription	Transcription Services	5,791				Entertainment Expense	( )	
Allen Leftkovitz	Real Estate Fees	1,301				(agree to Sch. V, line 24, col. 8)		
See Supplemental Schedule		342,266				TOTAL	\$ 5,059	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 417,775	TOTAL				
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn# 0040303

Report Period Beginning:

01/01/14

Ending:

12/31/14**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 387 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 209,289  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.