

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671 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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,263	1,520	4,034	15,817	8
9	SNF/PED					9
10	ICF	11,115			11,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,378	1,520	4,034	26,932	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.56%

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 05/01/97

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

YES Date 05/01/97 NO

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

YES NO If YES, enter number of beds certified 53 and days of care provided 3,440

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr # 0042671 Report Period Beginning: 01/01/14 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
	A. General Services										
1	Dietary	153,524	19,586	6,427	179,537		179,537	87	179,624		1
2	Food Purchase		176,428		176,428		176,428	(531)	175,897		2
3	Housekeeping	111,642	15,832		127,474		127,474	292	127,766		3
4	Laundry	37,261	12,298	2,332	51,891		51,891		51,891		4
5	Heat and Other Utilities			107,303	107,303		107,303	659	107,962		5
6	Maintenance	76,297		97,650	173,947		173,947	12,467	186,414		6
7	Other (specify):* See Supplemental			139	139		139	445	584		7
8	TOTAL General Services	378,724	224,144	213,851	816,719		816,719	13,419	830,138		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,192,994	95,799	7,431	1,296,224		1,296,224		1,296,224		10
10a	Therapy	13,698			13,698		13,698		13,698		10a
11	Activities	45,716	16,216		61,932		61,932		61,932		11
12	Social Services	54,889		3,478	58,367		58,367		58,367		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,307,297	112,015	28,909	1,448,221		1,448,221		1,448,221		16
	C. General Administration										
17	Administrative	110,369			110,369		110,369	11,581	121,950		17
18	Directors Fees										18
19	Professional Services			235,090	235,090		235,090	(128,433)	106,657		19
20	Dues, Fees, Subscriptions & Promotions			22,274	22,274		22,274	(11,527)	10,747		20
21	Clerical & General Office Expenses	87,173	3,729	640,377	731,279		731,279	(558,597)	172,682		21
22	Employee Benefits & Payroll Taxes			325,178	325,178		325,178	(1,656)	323,522		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,438	4,438		4,438	150	4,588		24
25	Other Admin. Staff Transportation			29,375	29,375		29,375	738	30,113		25
26	Insurance-Prop.Liab.Malpractice			136,966	136,966		136,966	7,680	144,646		26
27	Other (specify):* See Supplemental							14,019	14,019		27
28	TOTAL General Administration	197,542	3,729	1,393,698	1,594,969		1,594,969	(666,045)	928,924		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,883,563	339,888	1,636,458	3,859,909		3,859,909	(652,626)	3,207,283		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security			139
Alloc. - Extended Care Consulting, LLC			445
Total	-	-	584

Line 15 Detailed

Total	-	-	-
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Line 27 Detailed

Alloc. - Extended Care Consulting, LLC			14,019
Total	-	-	14,019

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Vendor	Amount	Allowable
Care Consulting of Illinois	3,295	3,295
Kelly Rothering	6,243	6,243
West Central Mass Transit	6	6
Lisa Sandrson	2,104	2,104
Care Management Facility	368	368
Cummins Crosspoint	845	845
Enterprise Fleet Management	1,155	1,155
Laura Sepessy	1,504	1,504
Southern Bus & Mobility	2,370	2,370
Drake-Scruggs Equipment	1,623	1,623
Care Management Facility	435	435
Tana Hinthorne	1,646	1,646
Karen Morg	120	120
Meaka Knight	417	417
Patricia Bedwell	2,667	2,667
Other	4,576	4,576
Alloc. - Extended Care Consulting, LLC	738	738
Total	30,113	30,113

Facility Name & ID Number

Prairie Village Hlthcare Ctr

#0042671

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	
	D. Ownership											
30	Depreciation			25,697	25,697		25,697	79,180	104,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,247	13,247		13,247	122,899	136,146			32
33	Real Estate Taxes							26,053	26,053			33
34	Rent-Facility & Grounds			284,150	284,150		284,150	(284,150)				34
35	Rent-Equipment & Vehicles			12,739	12,739		12,739	434	13,173			35
36	Other (specify):* See Supplemental							11,505	11,505			36
37	TOTAL Ownership			335,833	335,833		335,833	(44,079)	291,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,238	605,266	879,504		879,504		879,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			207,016	207,016		207,016		207,016			42
43	Other (specify):* See Supplemental	150,411			150,411		150,411	(150,411)				43
44	TOTAL Special Cost Centers	150,411	274,238	812,282	1,236,931		1,236,931	(150,411)	1,086,520			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,033,974	614,126	2,784,573	5,432,673		5,432,673	(847,116)	4,585,557			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/14 - 12/31/14

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Prairie View Healthcare Center, LLC Mortgage Insurance Premiums			11,505
Total	-	-	11,505

Line 43 Detailed

Non-Allowable	150,411		
Total	150,411	-	-

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,453)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(922)	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	(500)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(597,539)	21		24
25	Fund Raising, Advertising and Promotional	(12,487)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(196,258)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (811,159)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,957)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,957)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (847,116)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	

Prairie Village Hlthcare Ctr

ID# 0042671

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized Items Expenses < \$2,500	\$ 5,060	6	1
2	Other Income	(9,470)	21	2
3	Collections	(2,677)	19	3
4	Bank Charges	(14,494)	21	4
5	Other Expenses	(118)	21	5
6	Theft Loss	(397)	21	6
7	Legal	(4,938)	19	7
8	Other Professional	(5,973)	19	8
9	Other	(150,411)	43	9
10				10
11				11
12				12
13				13
14	Prairie Village Healthcare Center, LLC			14
15	Professional Fees	(10,250)	19	15
16	Office	(34)	21	16
17	Amortization	(2,556)	31	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(196,258)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

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	0	0	87	0	0	0	0	0	0	0	0	87	1
2	Food Purchase	(922)	0	391	0	0	0	0	0	0	0	0	(531)	2
3	Housekeeping	0	0	292	0	0	0	0	0	0	0	0	292	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	659	0	0	0	0	0	0	0	0	659	5
6	Maintenance	5,060	0	2,720	4,687	0	0	0	0	0	0	0	12,467	6
7	Other (specify):*	0	0	0	445	0	0	0	0	0	0	0	445	7
8	TOTAL General Services	4,138	0	4,149	5,132	0	13,419	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	1,808	9,773	0	0	0	0	0	0	0	11,581	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,838)	10,250	(114,845)	0	0	0	0	0	0	0	0	(128,433)	19
20	Fees, Subscriptions & Promotions	(12,487)	0	960	0	0	0	0	0	0	0	0	(11,527)	20
21	Clerical & General Office Expenses	(622,552)	34	6,576	57,345	0	0	0	0	0	0	0	(558,597)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(1,656)	0	0	0	0	0	0	0	(1,656)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	150	0	0	0	0	0	0	0	0	150	24
25	Other Admin. Staff Transportation	0	0	738	0	0	0	0	0	0	0	0	738	25
26	Insurance-Prop.Liab.Malpractice	0	6,886	794	0	0	0	0	0	0	0	0	7,680	26
27	Other (specify):*	0	0	0	14,019	0	0	0	0	0	0	0	14,019	27
28	TOTAL General Administration	(658,877)	17,170	(103,819)	79,481	0	(666,045)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(654,739)	17,170	(99,670)	84,613	0	(652,626)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	76,735	2,445	0	0	0	0	0	0	0	0	79,180	30
31	Amortization of Pre-Op. & Org.	(2,556)	2,556	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,453)	125,792	560	0	0	0	0	0	0	0	0	122,899	32
33	Real Estate Taxes	0	24,628	1,425	0	0	0	0	0	0	0	0	26,053	33
34	Rent-Facility & Grounds	0	(284,150)	0	0	0	0	0	0	0	0	0	(284,150)	34
35	Rent-Equipment & Vehicles	0	0	434	0	0	0	0	0	0	0	0	434	35
36	Other (specify):*	0	11,505	0	0	0	0	0	0	0	0	0	11,505	36
37	TOTAL Ownership	(6,009)	(42,934)	4,864	0	0	0	0	0	0	0	0	(44,079)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(150,411)	0	0	0	0	0	0	0	0	0	0	(150,411)	43
44	TOTAL Special Cost Centers	(150,411)	0	0	0	0	0	0	0	0	0	0	(150,411)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(811,159)	(25,764)	(94,806)	84,613	0	(847,116)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 284,150	Prairie Village Healthcare Center, LLC	100.00%	\$	\$ (284,150)	1
2	V	32 Interest	765	Prairie Village Healthcare Center, LLC	100.00%		(765)	2
3	V	19 Professional Fees		Prairie Village Healthcare Center, LLC	100.00%	10,250	10,250	3
4	V	21 Office		Prairie Village Healthcare Center, LLC	100.00%	34	34	4
5	V	26 Property Insurance		Prairie Village Healthcare Center, LLC	100.00%	6,886	6,886	5
6	V	30 Depreciation		Prairie Village Healthcare Center, LLC	100.00%	76,735	76,735	6
7	V	31 Amortization		Prairie Village Healthcare Center, LLC	100.00%	2,556	2,556	7
8	V	32 Interest		Prairie Village Healthcare Center, LLC	100.00%	126,557	126,557	8
9	V	33 Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	24,628	24,628	9
10	V	36 Mortgage Insurance Premiums		Prairie Village Healthcare Center, LLC	100.00%	11,505	11,505	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 284,915			\$ 259,151	\$ * (25,764)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/14

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	Sherwin I. Ray	33.33%	Avenue Care Nursing and Rehab	Chicago, IL	Ex. Care Consulting		Home Office	1
2	Jakob Bakst	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Clinical		Administrative	2
3	Eric Rothner	33.34%	Briar Place	Indian Head, IL	CC Health Systems		Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA		Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main		Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents		Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab		Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical		Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light		Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			South Suburban Rehabilitation Center	Chicago, IL	Prairie Village			11
12			Tri-State Nursing and Rehab	Lansing, IL	Healthcare CTR	Jacksonville, IL	Bldg. Company	12
13			Wheaton Care Center	Wheaton, IL				13
14			Kensington Place Nursing and Rehab	Chicago, IL				14
15			Countryside Nursing and Rehab	Dolton, IL				15
16			Spring Creek Nursing and Rehab	Joliet, IL				16
17			Park House Nursing and Rehab	Chicago, IL				17
18			Timber Point Healthcare Center	Camp Point, IL				18
19			Prairie Village Healthcare Center	Jacksonville, IL				19
20			Major Hospital - Dyer	Dyer, IN				20
21			Major Hospital - Lake County	East Chicago, IN				21
22			Major Hospital - Sebo	Holbart, IN				22
23			Major Hospital - Lincolnshire	Merrillville, IN				23
24			Major Hospital - Munster	Munster, IN				24
25			McKinley Health Care Center	Canton, OH				25
26			St. James Manor	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 87	\$	87	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	391		391	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	292		292	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	659		659	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,720		2,720	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,808		1,808	20
21	V	19 Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	5,155		(114,845)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	960		960	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	6,576		6,576	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	150		150	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	738		738	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	794		794	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,445		2,445	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	560		560	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,425		1,425	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	434		434	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 120,000			\$ 25,194	\$ *	(94,806)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 4,687	\$	4,687	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	445		445	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,773		9,773	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	57,345		57,345	20
21	V	21 Office and Clerical (Direct)	17,633	Extended Care Consulting, LLC	100.00%	17,633			21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,363		12,363	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,656		1,656	23
24	V	22 Employee Benefits	1,656					(1,656)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 19,289			\$ 103,902	\$ *	84,613	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$	\$
16	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 40,359	CCS VEBA	100.00%	\$ 40,359	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 40,359			\$ 40,359	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Prairie Village Hlthcare Ctr

0042671

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	Adam Vales	Relative	Clerical	0.00	See Attached	0.35	0.88%	Alloc. Salary	\$ 571	22 - 07	1
2	Sherwin Ray	Shareholder	Administration	33.33%	See Attached	5.38	13.45%	Salary	20,362	17 - 01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,933		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/14

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,251,572	31	\$ 4,057	\$ 26,932	\$ 87	1
2	2	Food	Patient Days	1,251,572	31	18,150	26,932	391	2
3	3	Housekeeping	Patient Days	1,251,572	31	13,578	26,932	292	3
4	5	Utilities	Patient Days	1,251,572	31	30,626	26,932	659	4
5	6	Maintenance	Patient Days	1,251,572	31	126,400	26,932	2,720	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	26,932	1,808	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	26,932	5,155	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	26,932	960	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	26,932	6,576	9
10	24	Travel and Seminar	Patient Days	1,251,572	31	6,989	26,932	150	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	26,932	738	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	26,932	794	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	26,932	2,445	13
14	32	Interest	Patient Days	1,251,572	31	26,010	26,932	560	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	26,932	1,425	15
16	35	Rent - Equipment and Auto	Patient Days	1,251,572	31	20,168	26,932	434	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 25,194	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,251,572	31	\$ 217,811	\$ 217,811	26,932	\$ 4,687	1
2	6	Maintenance	Direct	1	1			1		2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,251,572	31	20,665		26,932	445	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,251,572	31	454,189	454,189	26,932	9,773	5
6	21	Office and Clerical	Patient Days	1,251,572	31	2,664,950	2,664,951	26,932	57,346	6
7	21	Office and Clerical	Direct	1	1	17,633	17,633	1	17,633	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,251,572	31	574,509	574,509	26,932	12,363	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	1,656		1	1,656	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					\$ 3,951,413	\$ 3,929,093		\$ 103,903	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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 Care Centers Health Systems, Inc.
 Street Address 200 Howard Avenue #246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612 - 5662
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Profit Margin %	77,896	21	\$ 77,896		\$	1
2	10	Nursing	Profit Margin %	234	21	234			2
3	39	Ancillary	Profit Margin %	97,004	21	97,004			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					\$ 175,134		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %	9,580,898	12	\$ 8,898,201	\$	\$	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					\$ 8,898,201	\$	\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %		\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/14

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocations	1	1	\$ 40,359	\$ 1	\$ 40,359	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					\$ 40,359	\$	\$ 40,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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 Vent Lease, LLC
 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	39	Ancillary	Profit Margin %	18	\$ 110,244	\$		\$	1
2	32	Depreciation	Direct	1	2,695				2
3	30	Interest	Direct	1	2,944				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				\$ 115,883	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Heartland Bank - HUD		X	Mortgage			\$	\$ 2,270,477		\$ 126,557	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	HFG		X	Line of Credit						13,247	6									
7	Alloc. - Extended Care	X		Line of Credit						560	7									
8											8									
9	TOTAL Facility Related						\$	\$ 2,270,477		\$ 140,364	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Interest Income		X							(3,453)	12									
13	Interest Income - Bldg. Part.		X							(765)	13									
14	TOTAL Non-Facility Related						\$	\$		\$ (4,218)	14									
15	TOTALS (line 9+line14)						\$	\$ 2,270,477		\$ 136,146	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,505 Line # 36

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2013 report.		\$	24,800	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.)		\$	25,553	2
3. Under or (over) accrual (line 2 minus line 1).		\$	753	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	25,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	26,053	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2009	20,324	8	
	2010	20,680	9	
	2011	21,687	10	
	2012	23,375	11	
	2013	24,128	12	
2014 Real Estate Tax Accrual = \$24,128 * 1.048 = \$25,300				
Extended Care Consulting, LLC (Allocations) = \$1,425				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-17-100-012</u>	<u>Long Term Care Facility</u>	\$ <u>24,128.34</u>	\$ <u>24,128.34</u>
2. <u>Allocation</u>	<u>Long Term Care Facility</u>	\$ <u>162,082.08</u>	\$ <u>1,357.53</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>186,210.42</u></u>	\$ <u><u>25,485.87</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>8,686</u>	<u>1997</u>	<u>\$ 170,000</u>	<u>1</u>
2	<u>Alloc. - Ext. Care</u>			<u>6,868</u>	<u>2</u>
3	TOTALS	8,686		\$ 176,868	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Bed*s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	126		1997		\$ 1,114,539	\$ 28,577	39	\$ 28,577		\$ 498,937	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prairie Village Healthcare Center, Inc. (Operating Entity)										
10											10
11	Various		2002		4,490	165	27.5	165		1,988	11
12	Various		2003		13,083	577	15 - 27.5	577		6,632	12
13	Various		2004		5,343	190	27.5	190		2,106	13
14	Various		2005		4,475	298	15	298		2,833	14
15	Various		2006		13,021	523	15 - 27.5	523		4,401	15
16	Various		2007		7,421	389	15 - 27.5	389		2,880	16
17	Various		2009		11,377	419	5 - 27.5	419		3,662	17
18	Various		2010		7,607	277	27.5	277		1,348	18
19	Phone System		2011		5,707	208	10	208		726	19
20	Outside Patio		2011		3,725	135	15	135		429	20
21	Doors		2012		8,460	308	27.5	308		733	21
22	Stool Repair		2012		6,824	248	27.5	248		662	22
23	Fire Protection Engineering		2012		10,500	382	27.5	382		923	23
24	Alarm System		2014		4,784	130	27.5	130		130	24
25	Fire Sprinkler Heads		2014		6,500	138	27.5	138		138	25
26	Rooftop Carrier AC		2014		8,924	189	27.5	189		189	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

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	
37 <u>Prairie Village Healthcare Center, LLC (Building Partnership)</u>		\$	\$		\$	\$	\$	37
38								38
39 <u>Various</u>	1997	487,113	12,490	39	12,490		214,458	39
40 <u>Various</u>	1998	185,832	4,764	39	4,764		79,393	40
41 <u>Various</u>	1999	3,549	91	39	91		1,369	41
42 <u>Various</u>	2000	9,164	333	27.5	333		4,769	42
43 <u>Various</u>	2001	54,531	1,983	27.5	1,983		27,310	43
44 <u>Various</u>	2008	134,167	5,056	15 - 27.5	5,056		31,456	44
45 <u>Various</u>	2009	63,595	2,313	27.5	2,313		12,816	45
46 <u>Various</u>	2010	14,295	367	39	367		1,726	46
47 <u>Addition - Carpentry, Millwork, Steel, Drywall, Concrete,</u>								47
48 <u>Roofing, Doors, Windows, Painting, Flooring, HVAC,</u>								48
49 <u>Plumbing, Electrical, Fire Alarm, Partitions, General</u>	2014	699,700	18,023	27.5	18,023		18,023	49
50 <u>Sprinkler System</u>	2014	106,300	2,738	27.5	2,738		2,738	50
51								51
52								52
53 <u>Related Party Allocations - See Supplemental Schedules</u>								53
54								54
55 <u>Allocations - Extended Care Consulting, LLC</u>	2007	99	5		5		40	55
56 <u>Allocations - Extended Care Consulting, LLC</u>	2009	59	3		3		18	56
57 <u>Allocations - Extended Care Consulting, LLC</u>	2010	581	29		29		145	57
58 <u>Allocations - Extended Care Consulting, LLC</u>	2011	209	10		10		42	58
59 <u>Allocations - Extended Care Consulting, LLC</u>	2013	69	3		3		10	59
60 <u>Allocations - Extended Care Consulting, LLC</u>	2014	954	48		48		48	60
61								61
62								62
63 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	9,464	243		243		2,983	63
64 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	7,818	666		666		7,818	64
65 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2003	9,214	785		785		9,214	65
66 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2005	758	49		49		408	66
67 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2009	83	4		4		25	67
68 <u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2014	1,319	66		66		66	68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,025,653	\$ 83,222		\$ 83,222	\$	\$ 943,590	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 209,483	\$ 11,178	\$ 11,178	\$	5 - 7	\$ 203,098	71
72	Current Year Purchases	17,279	10,367	10,367		5	10,367	72
73	Fully Depreciated Assets							73
74	See Supplemental	136,856						74
75	TOTALS	\$ 363,618	\$ 21,546	\$ 21,546	\$		\$ 213,465	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	Alloc. - Ext. Care Consult.			\$ 3,883	\$ 110	\$ 110	\$		\$ 3,445	76
77										77
78										78
79										79
80	TOTALS			\$ 3,883	\$ 110	\$ 110	\$		\$ 3,445	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)	\$ 3,570,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 104,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,877	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,160,500	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/14 - 12/31/14

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Prairie Village Healthcare Center, LLC			
Prior	69,000		69,000
Current			
Total	69,000	-	69,000
Related Party 2 - Extended Care Consulting, LLC			
Prior	63,643	265	62,374
Current	1,592	159	159
Total	65,235	424	62,533
Related Party 3 - Extended Care Consulting, LLC / 2201 Main, LLC			
Prior	2,621		2,621
Current			
Total	2,621	-	2,621
Related Party 4 - Vent Lease (Matrix Software)			
Prior			
Current			
Total	-	-	-
Total	136,856	424	134,154

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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 - Related Party

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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.	<u> /2015</u>	\$ _____
13.	<u> /2016</u>	\$ _____
14.	<u> /2017</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 13,173 Description: See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	296,947	\$		\$	296,947	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				26,910				26,910	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				218,074				218,074	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					256,081			256,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Supplemental</u>	39 - 02						18,157			18,157	12
13	Other (specify): <u>See Supplemental</u>	39 - 03					63,335				63,335	13
14	TOTAL			\$		\$	605,266	\$	274,238	\$	879,504	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	2,768	
Oxygen	15,389	
Wheelchairs and Walkers		1,742
Low Pressure Mattress		4,647
Food Pump		7,726
Laboratory		14,979
Radiology		6,550
Ambulance		9,504
Other		18,187
Total	<u>18,157</u>	<u>63,335</u>

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

Report 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 131	1
2	Cash-Patient Deposits	38,825	38,825	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>554,907</u>)	929,507	929,507	3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,733	27,733	6
7	Other Prepaid Expenses	1,161	1,161	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	5,217	5,217	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,002,443	\$ 1,002,574	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,114,539	14
15	Leasehold Improvements, at Historical Cost	125,804	1,884,050	15
16	Equipment, at Historical Cost	239,968	308,968	16
17	Accumulated Depreciation (book methods)	(256,362)	(1,218,354)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	260,048	968,474	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 369,458	\$ 3,227,677	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,371,901	\$ 4,230,251	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,173,432	\$ 1,327,332	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,327	32,327	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,272	108,272	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,944	4,944	31
32	Accrued Real Estate Taxes(Sch.IX-B)		25,300	32
33	Accrued Interest Payable		10,406	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	508,398	933,604	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,827,373	\$ 2,442,185	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,270,477	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,270,477	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,827,373	\$ 4,712,662	46
47	TOTAL EQUITY(page 18, line 24)	\$ (455,472)	\$ (482,411)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,371,901	\$ 4,230,251	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due from Employees	246	246
Due from Others	4,971	4,971
Total	5,217	5,217
Line 23 - Other Long Term Assets		
Construction in Progress	259,848	259,848
State Replacement Tax Benefit	200	200
Escrow Deposits and Replacement Reserves		660,185
Financing Costs (Net of Amortization)		48,241
Total	260,048	968,474
Line 36 - Other Current Liabilities		
Due to Related Parties	508,398	933,604
Total	508,398	933,604
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (129,890)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (129,890)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(325,582)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (325,582)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (455,472)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,925,557	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,925,557	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,497	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 168,497	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,453	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,453	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	9,584	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,584	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,107,091	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	816,719	31
32	Health Care	1,448,221	32
33	General Administration	1,594,969	33
B. Capital Expense			
34	Ownership	335,833	34
C. Ancillary Expense			
35	Special Cost Centers	1,029,915	35
36	Provider Participation Fee	207,016	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,432,673	40
41	Income before Income Taxes (line 30 minus line 40)**	(325,582)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (325,582)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,852,654	44
45	Private Pay - Net Inpatient Revenue	223,535	45
46	Medicare - Net Inpatient Revenue	1,541,277	46
47	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	33,992	47
48	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	274,099	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,925,557	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr

0042671

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	1,893	2,063	\$ 74,072	\$ 35.90	1
2	Assistant Director of Nursing	1,934	2,171	49,892	22.98	2
3	Registered Nurses	6,648	7,352	195,394	26.58	3
4	Licensed Practical Nurses	17,742	19,250	372,228	19.34	4
5	CNAs & Orderlies	43,164	46,133	480,632	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,317	1,230	13,698	11.14	8
9	Activity Director	2,090	2,486	29,974	12.06	9
10	Activity Assistants	1,580	1,796	15,742	8.77	10
11	Social Service Workers	2,705	3,007	54,889	18.25	11
12	Dietician					12
13	Food Service Supervisor	1,777	2,123	32,653	15.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,778	13,304	120,871	9.09	15
16	Dishwashers					16
17	Maintenance Workers	5,868	6,441	76,297	11.85	17
18	Housekeepers	11,764	12,925	111,642	8.64	18
19	Laundry	3,787	4,281	37,261	8.70	19
20	Administrator	1,791	2,155	90,007	41.77	20
21	Assistant Administrator					21
22	Other Administrative	280	282	20,362	72.21	22
23	Office Manager					23
24	Clerical	3,819	4,290	87,173	20.32	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	1,676	1,890	20,776	10.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Non-Allowable</u>	2,086	2,086	150,411	72.10	33
34	TOTAL (lines 1 - 33)	123,699	135,265	\$ 2,033,974 *	\$ 15.04	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 6,427	01 - 03	35
36	Medical Director	18,000	09 - 03	36
37	Medical Records Consultant	1,652	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,779	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	3,478	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 35,336		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kelly Rothering	Administrator	0	\$ 90,007	Workers' Compensation Insurance	\$ 63,329	IDPH License Fee	\$	
Sherwin Ray	Administration	33.33	20,362	Unemployment Compensation Insurance	46,148	Advertising: Employee Recruitment	33	
				FICA Taxes	153,066	Health Care Worker Background Check	2,216	
				Employee Health Insurance	40,359	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Public Relations	12,487	
				Employee Physicals	8,214	Dues and Subscriptions	4,516	
				Holiday Expense	10,806	Licenses	3,022	
				Other Employee Welfare	1,600	Alloc. - Extended Care Consulting	960	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,369			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(12,487)	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 323,522	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,747	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Extended Care Consulting, LLC	Home Office		\$ 120,000			\$	Out-of-State Travel	\$
Personnel Planners, Inc.	Unemployment Consultant		2,100					
Plante & Moran, PLLC	Accounting		19,500					
Krupnick, Bokor & Kagda	Accounting		3,847				In-State Travel	
Paycor	Data Processing / IT		12,820					
Medifax / EDI	Data Processing / IT		1,206					
E-Health Data Solutions	Data Processing / IT		5,775					
American Data	Data Processing / IT		6,198				Seminar Expense	4,438
MDI / Achieve	Data Processing / IT		2,424				Alloc. - Extended Care Consulting	150
Matrix Care	Data Processing / IT		4,733					
Nebo Systems	Data Processing / IT		116					
See Supplemental Schedule			56,371				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 235,090	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,588

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/14 - 12/31/14

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Care Consultants of Illinois	Data Processing / IT	6,931
Singer Networks	Data Processing / IT	2,697
Netrix	Data Processing / IT	1,188
Ability Network	Data Processing / IT	980
Microcenter	Data Processing / IT	48
National Datacare Corporation	Data Processing / IT	1,946
Other	Data Processing / IT	6,309
Burke, Warren, MacKay & Serritella, P.C.	Legal	913
Daniel Maher Law Offices	Legal	3,420
Williams, Montgomery & John, Ltd.	Legal	3,101
Holly Turner	Legal	250
Roff	Legal	3
Chuhak & Tecsccon	Legal	921
Foley & Lardner	Legal	1,602
Grabowski Law Services, LLC	Collections	2,677
HFG	Other	5,973
Blymas	Accounting / Tax	9,974
Benton & Associates	Land Surveyor	5,594
Other	Other	1,844
Total		56,371

**Prairie Village Hlthcare Ctr
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Allowable	Non-Allowable Amount
Williams, Montgomery & John, Ltd.	01/20/14	Non-Allowable		61
Burke, Warren, MacKay & Serritella, P.C.	01/23/14	Non-Allowable		122
Daniel Maher Law Offices	02/05/14	Lawsuit - MM	920	
Williams, Montgomery & John, Ltd.	02/17/14	Non-Allowable		82
Burke, Warren, MacKay & Serritella, P.C.	02/28/14	Non-Allowable		119
Daniel Maher Law Offices	03/11/14	Lawsuit - MM	100	
Williams, Montgomery & John, Ltd.	03/19/14	Non-Allowable		41
Burke, Warren, MacKay & Serritella, P.C.	03/27/14	Non-Allowable		36
Daniel Maher Law Offices	04/14/14	Lawsuit - MM	160	
Williams, Montgomery & John, Ltd.	04/30/14	Non-Allowable		94
Daniel Maher Law Offices	05/05/14	Lawsuit - MM	180	
Burke, Warren, MacKay & Serritella, P.C.	05/15/14	Non-Allowable		83
Williams, Montgomery & John, Ltd.	05/15/14	Non-Allowable		33
Burke, Warren, MacKay & Serritella, P.C.	05/18/14	Non-Allowable		99
Chuhak & Tecson	06/18/14	Non-Allowable		178
Williams, Montgomery & John, Ltd.	07/11/14	Non-Allowable		8
Burke, Warren, MacKay & Serritella, P.C.	07/23/14	Non-Allowable		13
Chuhak & Tecson	07/31/14	Non-Allowable		492
Burke, Warren, MacKay & Serritella, P.C.	08/15/14	Non-Allowable		17
Chuhak & Tecson	08/31/14	Non-Allowable		247
Daniel Maher Law Offices	09/04/14	Lawsuit - MM	620	
Williams, Montgomery & John, Ltd.	09/11/14	Non-Allowable		947
Burke, Warren, MacKay & Serritella, P.C.	09/22/14	Non-Allowable		298
Chuhak & Tecson	09/22/14	Non-Allowable		89
Roff Goffman	09/26/14	Non-Allowable		3
Holly Turner	10/01/14	Other Professional	250	
Daniel Maher Law Offices	10/15/14	Lawsuit - MM	640	
Williams, Montgomery & John, Ltd.	10/15/14	Non-Allowable		526
Burke, Warren, MacKay & Serritella, P.C.	10/23/14	Non-Allowable		26
Chuhak & Tecson	10/31/14	Non-Allowable		(186)
Chuhak & Tecson	10/31/14	Non-Allowable		101
Foley & Lardner	11/07/14	General Services - Cost Report Review	193	
Burke, Warren, MacKay & Serritella, P.C.	11/18/14	Non-Allowable		72
Williams, Montgomery & John, Ltd.	11/19/14	Non-Allowable		1,014
Daniel Maher Law Offices	11/24/14	Lawsuit - MM	440	
Daniel Maher Law Offices	12/05/14	Lawsuit - MM	180	
Foley & Lardner	12/11/14	General Services - Cost Report Review	1,410	
Daniel Maher Law Offices	12/16/14	Lawsuit - MM	180	
Williams, Montgomery & John, Ltd.	12/16/14	Non-Allowable		70
Burke, Warren, MacKay & Serritella, P.C.	12/31/14	Non-Allowable		30
Williams, Montgomery & John, Ltd.	12/31/14	Non-Allowable		226
Sub-Total			5,272	4,938

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Village Hlthcare Ctr# 0042671

Report Period Beginning:

01/01/14Ending: 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?
If YES, give association name and amount. N/A No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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?
If YES, give effective date of lease. No N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 207,016
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100 Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT