

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	425		1,254	1,679	8
9	SNF/PED					9
10	ICF	17,217	1,657	375	19,249	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,642	1,657	1,629	20,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.92%

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 1,254

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	116,464	9,554	6,906	132,924		132,924		132,924		1
2	Food Purchase		144,828		144,828		144,828	(48)	144,780		2
3	Housekeeping	107,260	25,120		132,380		132,380		132,380		3
4	Laundry	48,038	31,423		79,461		79,461		79,461		4
5	Heat and Other Utilities			55,394	55,394		55,394	(1,903)	53,491		5
6	Maintenance	30,502	55,392	26,967	112,861		112,861	17,325	130,186		6
7	Other (specify):*										7
8	TOTAL General Services	302,264	266,317	89,267	657,848		657,848	15,374	673,222		8
	B. Health Care and Programs										
9	Medical Director			8,300	8,300		8,300		8,300		9
10	Nursing and Medical Records	1,135,547	18,313	11,453	1,165,313		1,165,313	29,315	1,194,628		10
10a	Therapy	38,110	6,278		44,388		44,388		44,388		10a
11	Activities	56,913	3,997		60,910		60,910		60,910		11
12	Social Services	33,725		5,265	38,990		38,990		38,990		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,471	4,471		15
16	TOTAL Health Care and Programs	1,264,295	28,588	25,018	1,317,901		1,317,901	33,786	1,351,687		16
	C. General Administration										
17	Administrative	77,158			77,158		77,158	35,250	112,408		17
18	Directors Fees										18
19	Professional Services			327,853	327,853		327,853	(249,343)	78,510		19
20	Dues, Fees, Subscriptions & Promotions			12,507	12,507		12,507	(5,414)	7,093		20
21	Clerical & General Office Expenses	63,985	4,425	103,292	171,702		171,702	22,194	193,896		21
22	Employee Benefits & Payroll Taxes			251,236	251,236		251,236		251,236		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,413	6,413		6,413	184	6,597		24
25	Other Admin. Staff Transportation			9,532	9,532		9,532	6,786	16,318		25
26	Insurance-Prop.Liab.Malpractice			59,372	59,372		59,372	805	60,177		26
27	Other (specify):*							18,030	18,030		27
28	TOTAL General Administration	141,143	4,425	770,205	915,773		915,773	(171,509)	744,264		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,707,702	299,330	884,490	2,891,522		2,891,522	(122,350)	2,769,172		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 & ID Number

Prairie View Cr Ctr-Lewistown

#0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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			57,127	57,127		57,127	107,462	164,589			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,537	30,537		30,537	112,823	143,360			32
33	Real Estate Taxes			22,249	22,249		22,249	(5,435)	16,814			33
34	Rent-Facility & Grounds			48,000	48,000		48,000	(44,223)	3,777			34
35	Rent-Equipment & Vehicles			5,519	5,519		5,519	3,382	8,901			35
36	Other (specify):*											36
37	TOTAL Ownership			163,432	163,432		163,432	174,009	337,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,405	181,623	368,028		368,028		368,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,864	159,864		159,864		159,864			42
43	Other (specify):*			1,029	1,029		1,029	(1,029)	(0)			43
44	TOTAL Special Cost Centers		186,405	342,516	528,921		528,921	(1,029)	527,892			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,707,702	485,735	1,390,438	3,583,875		3,583,875	50,630	3,634,505			45

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

Prairie View Cr Ctr-Lewistown

ID# 0040303

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (242)	21	1
2	Marketing	(1,029)	43	2
3	Bank Charges	(16,224)	21	3
4	Additional R&M	17,320	06	4
5	Non-Allowable Legal	(4,222)	19	5
6				6
7				7
8				8
9				9
10	Building Co.			10
11	Accounting Fees	(1,480)	19	11
12	Amortization	(4,625)	31	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(10,502)		49

Prairie View Cr Ctr-Lewistown

Report Period Beginning: 01/01/15
 Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie View Cr Ctr-Lewistown# 0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(115)		67									(48)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,577)		674									(1,903)	5
6	Maintenance	17,320		5									17,325	6
7	Other (specify):*													7
8	TOTAL General Services	14,628		745									15,374	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			29,315									29,315	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,471									4,471	15
16	TOTAL Health Care and Programs			33,786									33,786	16
	C. General Administration													
17	Administrative			35,250									35,250	17
18	Directors Fees													18
19	Professional Services	(5,702)	1,480	(245,121)									(249,343)	19
20	Fees, Subscriptions & Promotions	(7,918)		2,504									(5,414)	20
21	Clerical & General Office Expenses	(56,147)		78,341									22,194	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			184									184	24
25	Other Admin. Staff Transportation			6,786									6,786	25
26	Insurance-Prop.Liab.Malpractice			805									805	26
27	Other (specify):*			18,030									18,030	27
28	TOTAL General Administration	(69,767)	1,480	(103,222)									(171,509)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,139)	1,480	(68,691)									(122,350)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	24,811	81,359	1,292									107,462	30
31	Amortization of Pre-Op. & Org.	(4,625)	4,625											31
32	Interest	(18)	112,825	16									112,823	32
33	Real Estate Taxes		(5,435)										(5,435)	33
34	Rent-Facility & Grounds		(48,000)	3,777									(44,223)	34
35	Rent-Equipment & Vehicles			3,382									3,382	35
36	Other (specify):*													36
37	TOTAL Ownership	20,168	145,374	8,467									174,009	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(1,029)											(1,029)	43
44	TOTAL Special Cost Centers	(1,029)											(1,029)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(36,000)	146,854	(60,224)									50,630	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 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 Tax Income	22,249	Prairie View Care Center of Lewistown, LLC	100.00%		(22,249)	2
3	V	19 Accounting Fees		Prairie View Care Center of Lewistown, LLC	100.00%	1,480	1,480	3
4	V	31 Amortization		Prairie View Care Center of Lewistown, LLC	100.00%	4,625	4,625	4
5	V	30 Depreciation		Prairie View Care Center of Lewistown, LLC	100.00%	81,359	81,359	5
6	V	32 Interest - Ren Mortgage		Prairie View Care Center of Lewistown, LLC	100.00%	24,990	24,990	6
7	V	32 Interest - Due to Ren LLC		Prairie View Care Center of Lewistown, LLC	100.00%	87,835	87,835	7
8	V	33 Real Estate Tax Expense		Prairie View Care Center of Lewistown, LLC	100.00%	16,814	16,814	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 70,249			\$ 217,103	\$ * 146,854	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 <u>FOOD</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	67	\$	67	15
16	V	5 <u>UTILITIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	674		674	16
17	V	6 <u>REPAIRS AND MAINTENANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	5		5	17
18	V	10 <u>NURSING</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	29,315		29,315	18
19	V	15 <u>EMP. BEN. HEALTHCARE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	4,471		4,471	19
20	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	14,268		14,268	20
21	V	19 <u>PROFESSIONAL FEES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	6,723		6,723	21
22	V	20 <u>DUES, FEES, SUBSCRIPTIONS</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	2,504		2,504	22
23	V	21 <u>SALARIES - CLERICAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	70,666		70,666	23
24	V	21 <u>OFFICE EXPENSES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	7,675		7,675	24
25	V	24 <u>SEMINAR EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	184		184	25
26	V	25 <u>AUTO & TRAVEL EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	6,786		6,786	26
27	V	26 <u>INSURANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	805		805	27
28	V	27 <u>EMP. BEN. GEN. ADMIN.</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	13,805		13,805	28
29	V	30 <u>DEPRECIATION</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	1,292		1,292	29
30	V	32 <u>INTEREST</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	16		16	30
31	V	34 <u>RENT</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	3,777		3,777	31
32	V	35 <u>EQUIPMENT RENTAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	488		488	32
33	V	35 <u>AUTO LEASE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	2,894		2,894	33
34	V								34
35	V	17 <u>ADMIN COMP - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	20,982		20,982	35
36	V	27 <u>EMP. BEN. - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	4,225		4,225	36
37	V	19 <u>HOME OFFICE EXPENSE</u>	251,844	<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%			(251,844)	37
38	V								38
39	Total		\$ 251,844			\$ 191,620	\$ *	(60,224)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Prairie View Cr Ctr-Lewistown

#

0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	5.25	10.49%	Alloc Salary	\$ 20,982	17-7	1	
2	Daniel Alter	Relative	Financial	0.00%	See Attached	3.67	10.49%	Alloc Salary	3,802	21-7	2	
3	Zev Geller	Relative	Clerical	0.00%	See Attached	0.92	10.49%	Alloc Salary	1,088	21-7	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	\$ 25,872		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-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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

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	199,483	6	639	20,928	67	1	
2	5	UTILITIES	PATIENT DAYS	199,483	6	6,424	20,928	674	2	
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	199,483	6	43	20,928	5	3	
4	10	NURSING	PATIENT DAYS	199,483	6	279,428	279,428	20,928	29,315	4
5	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	199,483	6	42,613	20,928	4,471	5	
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	199,483	6	136,000	136,000	20,928	14,268	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	199,483	6	64,080	20,928	6,723	7	
8	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	199,483	6	23,865	20,928	2,504	8	
9	21	SALARIES - CLERICAL	PATIENT DAYS	199,483	6	673,576	673,576	20,928	70,666	9
10	21	OFFICE EXPENSES	PATIENT DAYS	199,483	6	73,160	20,928	7,675	10	
11	24	SEMINAR EXPENSE	PATIENT DAYS	199,483	6	1,756	20,928	184	11	
12	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	199,483	6	64,679	20,928	6,786	12	
13	26	INSURANCE	PATIENT DAYS	199,483	6	7,669	20,928	805	13	
14	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	199,483	6	131,588	20,928	13,805	14	
15	30	DEPRECIATION	PATIENT DAYS	199,483	6	12,317	20,928	1,292	15	
16	32	INTEREST	PATIENT DAYS	199,483	6	148	20,928	16	16	
17	34	RENT	PATIENT DAYS	199,483	6	36,000	20,928	3,777	17	
18	35	EQUIPMENT RENTAL	PATIENT DAYS	199,483	6	4,652	20,928	488	18	
19	35	AUTO LEASE	PATIENT DAYS	199,483	6	27,586	20,928	2,894	19	
20									20	
21	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKE	50	6	200,000	200,000	5.25	20,982	21
22	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKE	50	6	40,273		5.25	4,225	22
23									23	
24									24	
25	TOTALS					\$ 1,826,494	\$ 1,289,004	\$ 191,620	25	

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown # 0040303 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Enloe		X							\$ 361	1									
2	Renaissance Care Center LLC	X		Mortgage	\$7,319.55	9/3/2009	3,028,781		9/1/2015	2.9000	87,834	2								
3	Bank Leumi		X	Mortgage				487,455			24,990	3								
4												4								
5												5								
Working Capital																				
6	Insurance Financing		X								878	6								
7	Bank Leumi		X	Working Capital				647,943			29,299	7								
8												8								
9	TOTAL Facility Related				\$7,319.55		\$ 3,028,781	\$ 1,135,398			\$ 143,362	9								
B. Non-Facility Related*																				
10	Allocated from Certified Health Management										16	10								
11	Interest Income		X								(18)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (2)	14								
15	TOTALS (line 9+line14)						\$ 3,028,781	\$ 1,135,398			\$ 143,360	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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-Lewistown

0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 2014 report.		\$	28,035	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.)		\$	22,099	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(5,936)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	22,750	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.		\$	16,814	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2010	<u>24,879</u>	8	
	2011	<u>25,884</u>	9	
	2012	<u>25,966</u>	10	
	2013	<u>21,923</u>	11	
	2014	<u>22,099</u>	12	
2015 Accrual: \$22,099 x 1.03 = \$22,750 (Rounded)				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2014	\$	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.

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>148,500</u>	1
2					2
3	TOTALS			\$ 148,500	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	\$ 81,359	27.5	\$ 97,200	\$ 15,841	\$ 1,466,014	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	24,124		20	(62)	(62)	25,171	9
10	Various		1994	16,141		20			16,141	10
11	Various		1995	1,113		20	30	30	1,113	11
12	Various		1997	15,843		20	792	792	14,642	12
13	Various		1998	8,800		20	440	440	7,918	13
14	Various		1999	21,882		20	1,094	1,094	18,007	14
15	Various		2001	11,953		20	557	557	9,151	15
16	Various		2002	1,750		20	88	88	1,181	16
17	Various		2003	11,023		20	551	551	6,752	17
18	Various		2004	13,699		20	685	685	7,877	18
19	Various		2005	9,041		20	452	452	4,834	19
20	Various		2006	18,227		20	911	911	8,695	20
21	Various		2007	14,892		20	745	745	6,485	21
22	Various		2008	30,045		20	2,205	2,205	20,589	22
23	Various		2010	35,192		20	1,760	1,760	10,190	23
24	Various		2011	2,650		20	133	133	585	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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		67,736			3,387	3,387	3,387	67
68		12,664	803		633	(170)	9,599	68
69			57,127			(57,127)		69
70		\$ 2,989,775	\$ 139,289		\$ 111,599	\$ (27,690)	\$ 1,638,332	70

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

Facility Name & ID Number Prairie View Cr Ctr-Lewistown# 0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,989,775	\$ 139,289		\$ 111,599	\$ (27,690)	\$ 1,638,332	1
2	Water Heater	2012	3,310		20	166	166	662	2
3	A/C Compressor	2012	4,261		20	213	213	763	3
4	Rooftop Hvac Units	2012	10,630		20	532	532	1,816	4
5	Video Monitor System	2012	8,043		20	1,149	1,149	4,404	5
6	Security Systems	2013	3,017		20	431	431	1,257	6
7	Landscaping Phase 1 And Phase 2	2013	6,025		20	402	402	937	7
8	Ellsworth Glass & Aluminum - Windows	2013	3,043		20	152	152	368	8
9	Carpet Tile And Cornices - Dining Room	2013	3,978		20	199	199	497	9
10	New Ceiling & Wall, Ceiling Repairs - Room 301	2013	2,800		20	140	140	350	10
11	Heat Exchanger For Laundry	2013	3,852		20	770	770	1,027	11
12	Plaster Repairs	2014	2,795		20	140	140	163	12
13	New Alarm / Camera / Monitoring System	2014	3,259		20	163	163	299	13
14	Firewall Upgrade In 3 Areas	2014	2,500		20	125	125	135	14
15	Roof Repairs	2014	9,500		20	475	475	554	15
16	Installation Of A/C Unit In Dining Room	2015	5,725		20	143	143	143	16
17	Addition Of Blackflow In Existing System	2015	6,200		20	284	284	284	17
18	Window Replacement	2015	38,280		20	1,914	1,914	1,914	18
19	A/C Sleeve Openings	2015	26,582		20	1,329	1,329	1,329	19
20	Boiler Replacement	2015	84,675		20	4,234	4,234	4,234	20
21	Roof Repairs	2015	3,850		20	193	193	193	21
22	Doors, Frame And Panic Bars	2015	9,267		20	463	463	463	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)		\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126	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		\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126	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)	\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126	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		\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126

**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		\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126	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)	\$ 3,231,366	\$ 139,289		\$ 125,215	\$ (14,074)	\$ 1,660,126	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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Asbestos Removal	2015	14,870		20	744	744	744	9
10	Facility Signage	2015	6,830		20	342	342	342	10
11	Refurbish 14 Doors For Painting	2015	4,620		20	231	231	231	11
12	Bathroom Remodeling- Doors, Paint, Walls	2015	20,647		20	1,032	1,032	1,032	12
13	A/C Units & Sleeves	2015	20,769		20	1,038	1,038	1,038	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)		\$ 67,736	\$		\$ 3,387	\$ 3,387	\$ 3,387	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Certified Health Management	1997	9,885	247	20	494	247	9,391	9
10	Allocated from Certified Health Management	2014	2,779	556	20	139	(417)	208	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)		\$ 12,664	\$ 803		\$ 633	\$ (170)	\$ 9,599	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		\$ 67,736	\$		\$ 3,387	\$ 3,387	\$ 3,387	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)	\$ 67,736	\$		\$ 3,387	\$ 3,387	\$ 3,387	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		\$ 12,664	\$ 803		\$ 633	\$ (170)	\$ 9,599	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)	\$ 12,664	\$ 803		\$ 633	\$ (170)	\$ 9,599	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	\$ 232,126	\$ 475	\$ 37,007	\$ 36,532	10	\$ 125,246	71
72	Current Year Purchases	29,115	14	2,344	2,330	10	2,344	72
73	Fully Depreciated Assets	303,108		23	23	10	303,080	73
74								74
75	TOTALS	\$ 564,350	\$ 489	\$ 39,374	\$ 38,885		\$ 430,670	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										78
79										79
80	TOTALS			\$ 24,912	\$	\$	\$		\$ 24,912	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)	\$ 3,969,128	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,778	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,589	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,811	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,115,708	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.

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	<u>Allocated from Certified Health Management</u>				<u>3,777</u>			5
6								6
7	TOTAL				\$ <u>3,777</u>			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,007 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	<u>Allocated from Certified Health Management</u>		\$	\$ <u>2,894</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,894</u>	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2016</u>	\$ _____
13.	<u>/2017</u>	\$ _____
14.	<u>/2018</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8		
			Staff		Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	83,189	\$			\$	83,189	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				10,194					10,194	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				88,240					88,240	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						36,918			36,918	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>								149,487			149,487	13	
14	TOTAL			\$			\$	181,623	\$	186,405		\$	368,028	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-Lewistown# 0040303Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 11,901	\$ 36,462	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,418,210	1,418,210	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,921	46,921	6
7	Other Prepaid Expenses	427	427	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	644	84,644	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,478,103	\$ 1,586,664	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		148,500	13
14	Buildings, at Historical Cost		2,673,000	14
15	Leasehold Improvements, at Historical Cost	346,046	583,329	15
16	Equipment, at Historical Cost	383,499	531,999	16
17	Accumulated Depreciation (book methods)	(493,057)	(1,714,154)	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	53,396	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 265,475	\$ 2,276,070	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,743,578	\$ 3,862,734	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 418,360	\$ 418,359	26
27	Officer's Accounts Payable	330,970	330,970	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	647,943	647,943	29
30	Accrued Salaries Payable	94,636	94,636	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,926	5,926	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,750	22,750	32
33	Accrued Interest Payable	94,344	642,729	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	58,188	58,188	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,673,117	\$ 2,221,501	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		487,455	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	2,978,334	4,965,113	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,978,334	\$ 5,452,568	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,651,451	\$ 7,674,069	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,907,873)	\$ (3,811,335)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,743,578	\$ 3,862,734	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,777,786)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,777,787)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(130,086)	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)	\$ (130,086)	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)	\$ (2,907,873)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Prairie View Cr Ctr-Lewistown

0040303

Report Period Beginning: 01/01/15

Ending:

12/31/15

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	\$ 3,012,890	1
2	Discounts and Allowances for all Levels	344,419	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,357,309	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	89,338	6
7	Oxygen	991	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,329	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	508	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,548	19
20	Radiology and X-Ray	1,507	20
21	Other Medical Services	1,328	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,891	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	242	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 242	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,453,789	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	657,848	31
32	Health Care	1,317,901	32
33	General Administration	915,773	33
B. Capital Expense			
34	Ownership	163,432	34
C. Ancillary Expense			
35	Special Cost Centers	369,057	35
36	Provider Participation Fee	159,864	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,583,875	40
41	Income before Income Taxes (line 30 minus line 40)**	(130,086)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (130,086)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,266,948	44
45	Private Pay - Net Inpatient Revenue	266,399	45
46	Medicare - Net Inpatient Revenue	547,707	46
47	Other-(specify) <u>Managed Care</u>	75,963	47
48	Other-(specify) <u>Hospice</u>	200,292	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,357,309	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-Lewistown**

0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,653	1,968	\$ 64,645	\$ 32.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,398	7,473	196,293	26.27	3
4	Licensed Practical Nurses	12,433	12,687	298,539	23.53	4
5	CNAs & Orderlies	45,567	48,476	545,319	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,319	3,319	38,110	11.48	8
9	Activity Director	1,737	1,737	22,348	12.87	9
10	Activity Assistants	2,491	2,491	34,565	13.88	10
11	Social Service Workers	1,921	1,960	33,725	17.21	11
12	Dietician					12
13	Food Service Supervisor	1,820	1,820	28,983	15.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,993	8,993	87,481	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,702	1,702	30,502	17.92	17
18	Housekeepers	8,834	8,923	107,260	12.02	18
19	Laundry	4,069	4,110	48,038	11.69	19
20	Administrator	1,980	1,980	77,158	38.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,900	1,900	41,302	21.74	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	1,722	1,722	30,751	17.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,261	2,261	22,683	10.03	33
34	TOTAL (lines 1 - 33)	109,800	113,522	\$ 1,707,702 *	\$ 15.04	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	173	\$ 6,906	01-03	35
36	Medical Director	Monthly	8,300	09-03	36
37	Medical Records Consultant	46	2,239	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,214	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	51	5,265	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	\$ 31,924		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	\$ 43,097	Workers' Compensation Insurance	\$ 37,561	IDPH License Fee	\$	
Lisa Lockwood	Administrator	0	34,061	Unemployment Compensation Insurance	27,542	Advertising: Employee Recruitment		
				FICA Taxes	128,303	Health Care Worker Background Check		
				Employee Health Insurance	50,211	(Indicate # of checks performed <u>92</u>)	925	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	2,323	
				Other Employee Benefits	3,380	Licenses and Permits	1,002	
				Pension Plan Contribution	4,240	Employee Hiring Costs	339	
						Allocated from Certified Health Mgmt.	2,504	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 77,158			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V,	\$ 7,093	
Description			Amount			line 20, col. 8)		
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal Fees	\$ 15,222			\$	Out-of-State Travel	\$	
FRR/Marcum LLP	Accounting Services	16,580						
Richard Peelo & Assoc.	Accounting Services	3,750						
Peterson Healthcare Consulting	Computer Services	2,250				In-State Travel		
E-Health Data Solutions	Computer Services	2,921						
Lora L Hebert	Computer Services	1,609						
Certified Health Management	Home Office Expense	251,844				Seminar Expense	6,413	
PayChex	Payroll Services	14,578				Allocated from Certified Health Mgmt.	184	
Personnel Planners	Unemployment Consulting	3,153						
Wescom Solutions Inc	Data Processing	15,946						
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)			\$ 327,853			line 24, col. 8)	\$ 6,597	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie View Cr Ctr-Lewistown# 0040303

Report Period Beginning:

01/01/15

Ending:

12/31/15**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 335 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. \$ 159,864
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.