

Facility Name & ID Number Prairie Rose Health Care Center

0045245 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 | 105 | Skilled (SNF) | 105 | 38,325 | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | | Intermediate (ICF) | | | 3 |
| 4 | | Intermediate/DD | | | 4 |
| 5 | | Sheltered Care (SC) | | | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | 105 | TOTALS | 105 | 38,325 | 7 |

B. Census-For the entire report period.

| | 1 Level of Care | 2 3 4 5 Patient Days by Level of Care and Primary Source of Payment | | | | |
|----|--------------------|------------------------------------------------------------------------|------------------|------------|------------|----|
| | | 2 Medicaid Recipient | 3 Private Pay | 4 Other | 5 Total | |
| 8 | SNF | 15,118 | 1,934 | 923 | 17,975 | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | | | | | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | 15,118 | 1,934 | 923 | 17,975 | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.90%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 3/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/1995 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 105 and days of care provided 863

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: 12/31/2017 Fiscal Year: 12/31/2017

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

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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 | 141,364 | 16,370 | | 157,734 | | 157,734 | | 157,734 | | 1 |
| 2 | Food Purchase | | 123,112 | | 123,112 | | 123,112 | (6,090) | 117,022 | | 2 |
| 3 | Housekeeping | 129,593 | 15,257 | | 144,850 | | 144,850 | | 144,850 | | 3 |
| 4 | Laundry | 18,480 | 11,706 | | 30,186 | | 30,186 | | 30,186 | | 4 |
| 5 | Heat and Other Utilities | | | 109,987 | 109,987 | | 109,987 | | 109,987 | | 5 |
| 6 | Maintenance | 38,003 | 5,808 | 25,522 | 69,333 | | 69,333 | | 69,333 | | 6 |
| 7 | Other (specify):* Home Office Ben. Allocation | | | | | | | | | | 7 |
| 8 | TOTAL General Services | 327,440 | 172,253 | 135,509 | 635,202 | | 635,202 | (6,090) | 629,112 | | 8 |
| | B. Health Care and Programs | | | | | | | | | | |
| 9 | Medical Director | | | 21,000 | 21,000 | | 21,000 | | 21,000 | | 9 |
| 10 | Nursing and Medical Records | 891,154 | 87,849 | 5,637 | 984,640 | | 984,640 | (6,536) | 978,104 | | 10 |
| 10a | Therapy | | | 117,999 | 117,999 | | 117,999 | | 117,999 | | 10a |
| 11 | Activities | 32,293 | 1,049 | 611 | 33,953 | | 33,953 | (134) | 33,819 | | 11 |
| 12 | Social Services | 40,757 | | | 40,757 | | 40,757 | | 40,757 | | 12 |
| 13 | CNA Training | | | | | | | | | | 13 |
| 14 | Program Transportation | | | | | | | | | | 14 |
| 15 | Other (specify):* Home Office Ben. Allocation | | | | | | | | | | 15 |
| 16 | TOTAL Health Care and Programs | 964,204 | 88,898 | 145,247 | 1,198,349 | | 1,198,349 | (6,670) | 1,191,679 | | 16 |
| | C. General Administration | | | | | | | | | | |
| 17 | Administrative | 76,742 | | 173,958 | 250,700 | | 250,700 | (92,803) | 157,897 | | 17 |
| 18 | Directors Fees | | | | | | | | | | 18 |
| 19 | Professional Services | | | 16,839 | 16,839 | | 16,839 | | 16,839 | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 6,557 | 6,557 | | 6,557 | (125) | 6,432 | | 20 |
| 21 | Clerical & General Office Expenses | 23,603 | 1,150 | 14,331 | 39,084 | | 39,084 | (4,952) | 34,132 | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 158,408 | 158,408 | | 158,408 | | 158,408 | | 22 |
| 23 | Inservice Training & Education | | | 495 | 495 | | 495 | | 495 | | 23 |
| 24 | Travel and Seminar | | | | | | | | | | 24 |
| 25 | Other Admin. Staff Transportation | | | 2,892 | 2,892 | | 2,892 | | 2,892 | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 52,097 | 52,097 | | 52,097 | | 52,097 | | 26 |
| 27 | Other (specify):* Home Office Ben. Allocation | | | | | | | | | | 27 |
| 28 | TOTAL General Administration | 100,345 | 1,150 | 425,577 | 527,072 | | 527,072 | (97,880) | 429,192 | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 1,391,989 | 262,301 | 706,333 | 2,360,623 | | 2,360,623 | (110,640) | 2,249,983 | | 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

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#0045245

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 | | | 106,224 | 106,224 | | 106,224 | (12,736) | 93,488 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | 12,568 | 12,568 | | 12,568 | | 12,568 | | | 31 |
| 32 | Interest | | | 173,414 | 173,414 | | 173,414 | (12,499) | 160,915 | | | 32 |
| 33 | Real Estate Taxes | | | 42 | 42 | | 42 | (42) | | | | 33 |
| 34 | Rent-Facility & Grounds | | | | | | | | | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 53,489 | 53,489 | | 53,489 | | 53,489 | | | 35 |
| 36 | Other (specify):* | | | | | | | | | | | 36 |
| 37 | TOTAL Ownership | | | 345,737 | 345,737 | | 345,737 | (25,277) | 320,460 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | | | | | 38 |
| 39 | Ancillary Service Centers | | 19,334 | | 19,334 | | 19,334 | | 19,334 | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | | | | | 41 |
| 42 | Provider Participation Fee | | | 160,906 | 160,906 | | 160,906 | | 160,906 | | | 42 |
| 43 | Other (specify):* | 6,852 | 1,472 | 41,122 | 49,446 | | 49,446 | (49,446) | | | | 43 |
| 44 | TOTAL Special Cost Centers | 6,852 | 20,806 | 202,028 | 229,686 | | 229,686 | (49,446) | 180,240 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 1,398,841 | 283,107 | 1,254,098 | 2,936,046 | | 2,936,046 | (185,363) | 2,750,683 | | | 45 |

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

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| NON-ALLOWABLE EXPENSES | | Amount | Sch. V Line Reference | |
|------------------------|-----------------------------------------------|------------|-----------------------|----|
| 1 | Labs-Part A | \$ (2,293) | 43 | 1 |
| 2 | X-Rays-Part A | (2,705) | 43 | 2 |
| 3 | Pet Expense | (1,156) | 43 | 3 |
| 4 | Disallowed R.E. Taxes | (42) | 33 | 4 |
| 5 | Management Fee Offset | (92,803) | 17 | 5 |
| 6 | Miscellaneous Revenue Offset-Nursing Supplies | (6,536) | 10 | 6 |
| 7 | Disallowed Marketing Expense | (6,852) | 43 | 7 |
| 8 | Disallowed Special Events | 144 | 43 | 8 |
| 9 | Disallowed Chamber of Commerce Dues | (125) | 20 | 9 |
| 10 | Transportation Revenue Offset | (134) | 11 | 10 |
| 11 | Escrow Refund | (12,004) | 32 | 11 |
| 12 | Miscellaneous Revenue Offset-Office Supplies | (4,952) | 21 | 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 | (129,458) | | 49 |

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 |
| SJL Health Systems, Inc. | 100 | See PG6-Supp | | See PG6-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: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|--------------|---------------------------|--------|--------------------------------|----------------------|----------------------------------------|----------------------------------------------------------------------|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 1 | V | | | | | | \$ | 1 |
| 2 | V | | | | | | | 2 |
| 3 | V | | | | | | | 3 |
| 4 | V | | | | | | | 4 |
| 5 | V | | | | | | | 5 |
| 6 | V | | | | | | | 6 |
| 7 | V | | | | | | | 7 |
| 8 | V | | | | | | | 8 |
| 9 | V | | | | | | | 9 |
| 10 | V | | | | | | | 10 |
| 11 | V | | | | | | | 11 |
| 12 | V | | | | | | | 12 |
| 13 | V | | | | | | | 13 |
| 14 | Total | | \$ | | | \$ | \$ * | 14 |

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

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1/1/2017

Ending:

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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 | | | | | | | | | \$ | | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | N/A | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ | | 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

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1/1/2017

Ending: 2/31/2017

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 | | N/A | | | | | | | 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 |

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1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

| 1 | Name of Lender | 2 | | 3 | 4 | 5 | 6 | | 7 | 8 | 9 | 10 | | | | | | |
|-------------------------------------|-----------------------------------|-----------|----|----------|-------------|----------|-----------------|--------------------------|----------|--------|-------------|----|--------------|----------------|---------|---------------|--------------------------|-----------------------------------|
| | | Related** | | | | | Purpose of Loan | Monthly Payment Required | | | | | Date of Note | Amount of Note | | Maturity Date | Interest Rate (4 Digits) | Reporting Period Interest Expense |
| | | YES | NO | | | | | | | | | | | Original | Balance | | | |
| A. Directly Facility Related | | | | | | | | | | | | | | | | | | |
| Long-Term | | | | | | | | | | | | | | | | | | |
| 1 | Wells Fargo | | X | Mortgage | \$21,167.65 | 12/01/02 | \$ 3,580,869 | \$ 2,796,175 | 11/01/35 | 0.0618 | \$ 173,414 | 1 | | | | | | |
| 2 | | | | | | | | | | | | 2 | | | | | | |
| 3 | | | | | | | | | | | | 3 | | | | | | |
| 4 | | | | | | | | | | | | 4 | | | | | | |
| 5 | | | | | | | | | | | | 5 | | | | | | |
| Working Capital | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | 6 | | | | | | |
| 7 | | | | | | | | | | | | 7 | | | | | | |
| 8 | | | | | | | | | | | | 8 | | | | | | |
| 9 | TOTAL Facility Related | | | | \$21,167.65 | | \$ 3,580,869 | \$ 2,796,175 | | | \$ 173,414 | 9 | | | | | | |
| B. Non-Facility Related* | | | | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | (495) | 10 | | | | | | |
| 11 | | | | | | | | | | | (12,004) | 11 | | | | | | |
| 12 | | | | | | | | | | | | 12 | | | | | | |
| 13 | | | | | | | | | | | | 13 | | | | | | |
| 14 | TOTAL Non-Facility Related | | | | | | \$ | \$ | | | \$ (12,499) | 14 | | | | | | |
| 15 | TOTALS (line 9+line14) | | | | | | \$ 3,580,869 | \$ 2,796,175 | | | \$ 160,915 | 15 | | | | | | |

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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 2016 report. | | \$ | | 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.) | | \$ | 42 | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | | \$ | 42 | 3 |
| 4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.) | | \$ | | 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.) | | \$ | (42) | 6 |
| 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6. | | \$ | | 7 |

Real Estate Tax History:

| | | | |
|-----------------------------------------|------|----|----|
| Real Estate Tax Bill for Calendar Year: | 2012 | 27 | 8 |
| | 2013 | 31 | 9 |
| | 2014 | 34 | 10 |
| | 2015 | 37 | 11 |
| | 2016 | 42 | 12 |

Accrual based on prior year tax bill.

| | | | |
|-------------------------|------------------------------------|----|----|
| FOR BHF USE ONLY | | | |
| 13 | FROM R. E. TAX STATEMENT FOR 2016 | \$ | 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.

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 443,042 2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 12,568 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

| | 1 | 2 | 3 | 4 | |
|---|-----------------|---------------|---------------|------------------|----------|
| | Use | Square Feet | Year Acquired | Cost | |
| 1 | <u>Facility</u> | <u>28,000</u> | <u>1995</u> | <u>\$ 13,500</u> | <u>1</u> |
| 2 | | | | | <u>2</u> |
| 3 | TOTALS | 28,000 | | \$ 13,500 | 3 |

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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 | 121 | | 1995 | 1976 | \$ 1,068,665 | \$ | 30 | \$ 35,622 | \$ 34,053 | \$ 813,370 | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | Improvement Type** | | | | | | | | | | |
| 9 | 1986 Additions | | 1986 | | 970,363 | | 30 | | | 970,363 | 9 |
| 10 | 1987 Additions | | 1987 | | 110,922 | | 30 | 263 | 263 | 110,922 | 10 |
| 11 | 1989 Additions | | 1989 | | 2,219 | | 10 | | | 2,219 | 11 |
| 12 | 1990 Additions | | 1990 | | 4,295 | | 30 | | | 4,295 | 12 |
| 13 | 1991 Additions | | 1991 | | 134,283 | | 7 | | | 134,283 | 13 |
| 14 | 1992 Additions | | 1992 | | 17,130 | | 7 | | | 17,130 | 14 |
| 15 | 1993 Additions | | 1993 | | 24,239 | | 7 | | | 24,239 | 15 |
| 16 | 1994 Additions | | 1994 | | 10,559 | | 7 | | | 10,559 | 16 |
| 17 | 1995 Additions | | 1995 | | 14,167 | | 15 | | | 14,167 | 17 |
| 18 | 1996 Additions | | 1996 | | 305,057 | | 12 | | | 305,057 | 18 |
| 19 | 1997 Additions | | 1997 | | 23,542 | | 10 | | | 23,542 | 19 |
| 20 | Whirlpool Bath | | 1998 | | 9,120 | | 10 | | | 9,120 | 20 |
| 21 | Lift, Bath Trolley | | 1998 | | 3,850 | | 10 | | | 3,850 | 21 |
| 22 | Shower Room | | 1998 | | 4,884 | | 10 | | | 4,884 | 22 |
| 23 | Entrance Doors | | 1998 | | 2,358 | | 20 | 118 | 118 | 2,271 | 23 |
| 24 | Curtains | | 1998 | | 6,102 | | 5 | | | 6,102 | 24 |
| 25 | Sidewalk & Pad | | 1999 | | 1,484 | | 15 | | | 1,484 | 25 |
| 26 | Divide Receipts on Emergency Generator | | 1999 | | 2,397 | | 20 | 120 | 120 | 2,219 | 26 |
| 27 | Med Room Cabinets and Counter Top | | 1999 | | 2,008 | | 20 | 100 | 100 | 1,804 | 27 |
| 28 | Door Alarms | | 2001 | | 1,215 | | 15 | 27 | 27 | 1,215 | 28 |
| 29 | Dining Room, Living Room, Shower Remodel | | 2001 | | 94,315 | | 30 | 3,144 | 3,144 | 52,137 | 29 |
| 30 | Wooded Doors | | 2001 | | 1,900 | | 15 | | | 1,900 | 30 |
| 31 | Landscaping-Renovation Project | | 2001 | | 1,174 | | 10 | | | 1,174 | 31 |
| 32 | Bituminous Parking Lot | | 2001 | | 22,030 | | 8 | | | 22,030 | 32 |
| 33 | Replace Plumbing Fixtures | | 2002 | | 2,490 | \$ | 20 | \$ 125 | 125 | 1,997 | 33 |
| 34 | Therapy Room Remodel | | 2002 | | 5,617 | | 20 | 281 | 281 | 4,355 | 34 |
| 35 | Remodel Medication/Utility Rooms | | 2002 | | 7,909 | | 20 | 395 | 395 | 6,125 | 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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 | |
| 37 | Breakroom Remodel | 2002 | 3,106 | | 10 | | | \$ 3,106 | 37 |
| 38 | Exterior Window Covering | 2002 | 7,650 | | 7 | | | 7,650 | 38 |
| 39 | Lights for Therapy Room | 2002 | 805 | | 10 | | | 805 | 39 |
| 40 | Renovation on Facility Floors and Walls | 2002 | 36,842 | | 20 | 1,842 | 1,842 | 27,784 | 40 |
| 41 | Fire Supression System | 2004 | 1,540 | | 10 | | | 1,540 | 41 |
| 42 | Antenna | 2004 | 2,944 | | 10 | | | 2,944 | 42 |
| 43 | Sign | 2004 | 1,200 | | 10 | | | 1,200 | 43 |
| 44 | Carpet | 2005 | 1,281 | | 5 | | | 1,281 | 44 |
| 45 | Sidewalks | 2006 | 8,735 | | 10 | | | 8,735 | 45 |
| 46 | Duct Work | 2007 | 5,120 | | 15 | 342 | 342 | 3,591 | 46 |
| 47 | Sidewalks | 2007 | 8,976 | | 15 | 598 | 598 | 6,279 | 47 |
| 48 | Water Heater & Duct Work | 2008 | 4,850 | | 10 | 485 | 485 | 4,608 | 48 |
| 49 | Air Conditioner-Rooftop | 2008 | 9,120 | | 10 | 912 | 912 | 5,574 | 49 |
| 50 | Plumbing Repair | 2008 | 3,442 | | 10 | 346 | 346 | 3,442 | 50 |
| 51 | Ceramic Tile Replacement | 2008 | 9,996 | | 20 | 500 | 500 | 4,750 | 51 |
| 52 | Vinyl Tile Replacement | 2008 | 4,495 | | 20 | 225 | 225 | 2,250 | 52 |
| 53 | Sidwalk Marquee | 2008 | 4,985 | | 10 | 499 | 499 | 4,740 | 53 |
| 54 | Generator Repair | 2008 | 2,562 | | 10 | 256 | 256 | 2,432 | 54 |
| 55 | Dementia Unit Remodeling-Architect and Engineering | 2008 | 14,466 | | 20 | 724 | 724 | 6,878 | 55 |
| 56 | Dementia Unit Remodeling-Demolition, Doors and Windows | 2008 | 13,168 | | 20 | 658 | 658 | 6,251 | 56 |
| 57 | Dementia Unit Remodeling-Drywall and Hand Railings | 2008 | 25,343 | | 20 | 1,268 | 1,268 | 12,046 | 57 |
| 58 | Dementia Unit Remodeling-Drywall and Hand Railings | 2008 | 10,796 | | 20 | 540 | 540 | 5,130 | 58 |
| 59 | Dementia Unit Remodeling-Drywall, Painting, and Electrical | 2008 | 20,841 | | 20 | 1,042 | 1,042 | 9,899 | 59 |
| 60 | Dementia Unit Remodeling-Carpeting & Flooring | 2008 | 29,889 | | 20 | 1,494 | 1,494 | 14,193 | 60 |
| 61 | Tiling for Bathroom | 2009 | 13,519 | | 15 | 902 | 902 | 7,667 | 61 |
| 62 | Generator Repair | 2009 | 3,984 | | 7 | | | 3,984 | 62 |
| 63 | Air Conditioner-Rooftop | 2009 | 10,281 | | 15 | 686 | 686 | 831 | 63 |
| 64 | Wandering Patient Alarm System | 2010 | 5,050 | | 7 | 357 | 357 | 5,050 | 64 |
| 65 | Sprinkler System Repair | 2009 | 33,658 | | 10 | 3,366 | 3,366 | 25,245 | 65 |
| 66 | Water Heater | 2011 | 3,356 | | 7 | 480 | 480 | 3,120 | 66 |
| 67 | Fire Alarm Control Installation | 2012 | 2,958 | | 7 | 422 | 422 | 2,321 | 67 |
| 68 | | | | | | | | | 68 |
| 69 | | | | | | | | | 69 |
| 70 | TOTAL (lines 4 thru 69) | | \$ 3,159,252 | \$ | | \$ 58,139 | \$ 56,570 | \$ 2,748,139 | 70 |

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

XI. OWNERSHIP COSTS (continued)

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

| 1 | 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 | Totals from Page 12A, Carried Forward | | \$ 3,159,252 | \$ | | \$ 58,139 | \$ 58,139 | \$ 2,748,139 | 1 |
| 2 | Landscaping | 2013 | 10,158 | | 15 | 678 | 678 | 3,051 | 2 |
| 3 | Parking Lot Repair | 2013 | 2,500 | | 7 | 358 | 358 | 1,611 | 3 |
| 4 | Water Pipe Repair | 2014 | 7,170 | | 7 | 1,024 | 1,024 | 3,584 | 4 |
| 5 | Gutters and Soft | 2014 | 7,936 | | 25 | 317 | 317 | 1,110 | 5 |
| 6 | Patio Replacement | 2014 | 9,592 | | 15 | 640 | 640 | 2,240 | 6 |
| 7 | Roof Replacement | 2015 | 222,650 | | 25 | 8,906 | 8,906 | 22,265 | 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 | Land Improvements Booked | | | 1,633 | | | (1,633) | | 28 |
| 29 | Building Booked | | | 63,722 | | | (63,722) | | 29 |
| 30 | Building Improvement Booked | | | 24,143 | | | (24,143) | | 30 |
| 31 | | | | | | | | | 31 |
| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 3,419,258 | \$ 89,498 | | \$ 70,062 | \$ (19,436) | \$ 2,782,000 | 34 |

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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 | \$ 121,555 | \$ 16,726 | \$ 23,426 | \$ 6,700 | 5-10 yrs. | \$ 90,068 | 71 |
| 72 | Current Year Purchases | | | | | 7 yrs. | | 72 |
| 73 | Fully Depreciated Assets | 1,082,675 | | | | | 1,082,675 | 73 |
| 74 | Home Office Allocation | | | | | | | 74 |
| 75 | TOTALS | \$ 1,204,230 | \$ 16,726 | \$ 23,426 | \$ 6,700 | | \$ 1,172,743 | 75 |

D. Vehicle Costs. (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|----|----------|---------------------------|--------------------|-----------|--------------------------------|---------------------------------|------------------|--------------------|-------------------------------|----|
| 76 | | | | | \$ | \$ | \$ | | \$ | 76 |
| 77 | | | | | | | | | | 77 |
| 78 | | | | | | | | | | 78 |
| 79 | | | | | | | | | | 79 |
| 80 | TOTALS | | | \$ | \$ | \$ | \$ | | \$ | 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) | \$ 4,636,988 | 81 |
| 82 | Current Book Depreciation | (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | \$ 106,224 | 82 |
| 83 | Straight Line Depreciation | (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | \$ 93,488 | 83** |
| 84 | Adjustments | (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) | \$ (12,736) | 84 |
| 85 | Accumulated Depreciation | (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable) | \$ 3,954,743 | 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 | N/A | | | | 89 |
| 90 | | | | | 90 |
| 91 | TOTALS | \$ | \$ | \$ | 91 |

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------|----|
| 92 | | \$ | 92 |
| 93 | N/A | | 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? YES NO
If NO, see instructions.

| | | 1 Year Constructed | 2 Number of Beds | 3 Original Lease Date | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|--------------------|--------------------------|------------------------|-----------------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: | | | | \$ | | | 3 |
| 4 | Additions | | | | | | | 4 |
| 5 | | | | | | | | 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>/2018</u> | \$ _____ |
| 13. | <u>/2019</u> | \$ _____ |
| 14. | <u>/2020</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: \$ 37,137 Description: See Attached Schedule 14A

(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>Facility</u> | <u>2015 Ford Van</u> | \$ <u>1,363.00</u> | \$ <u>16,352</u> | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | TOTAL | | \$ 1,363.00 | \$ 16,352 | 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.

Prairie Rose Health Care Center

0045245

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

| | |
|-------------------|---------------|
| Medical Equipment | \$ 31,032 |
| Dishwasher | 660 |
| Copier | 5,445 |
| | <u>37,137</u> |

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

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

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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 | | | |
|----|----------------------------------------|-----------|-----------|----------|-------|
| | | 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.

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

| | Service | Schedule V Line & Column Reference | Staff | | Outside Practitioner (other than consultant) | | Supplies (Actual or Allocated) | Total Units (Column 2 + 4) | Total Cost (Col. 3 + 5 + 6) | |
|----|--------------------------------------------------------------------------------|------------------------------------------|---------------------|------|-------------------------------------------------|------------|--------------------------------------|-------------------------------|--------------------------------|----|
| | | | Units of Service | Cost | Units | Cost | | | | |
| | | | | | | | | | | |
| 1 | Licensed Occupational Therapist | 10A(3) | hrs | \$ | 2,677 | \$ 40,154 | \$ | 2,677 | \$ 40,154 | 1 |
| 2 | Licensed Speech and Language Development Therapist | 10A(3) | hrs | | 1,266 | 18,993 | | 1,266 | 18,993 | 2 |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | 3 |
| 4 | Licensed Physical Therapist | 10A(3) | hrs | | 3,923 | 58,852 | | 3,923 | 58,852 | 4 |
| 5 | Physician Care | | visits | | | | | | | 5 |
| 6 | Dental Care | | visits | | | | | | | 6 |
| 7 | Work Related Program | | hrs | | | | | | | 7 |
| 8 | Habilitation | | hrs | | | | | | | 8 |
| 9 | Pharmacy | 39(2) | # of prescripts | | | | 19,334 | | 19,334 | 9 |
| 10 | Psychological Services (Evaluation and Diagnosis/ Behavior Modification) | | hrs | | | | | | | 10 |
| 11 | Academic Education | | hrs | | | | | | | 11 |
| 12 | Other (specify): _____ | | | | | | | | | 12 |
| 13 | Other (specify): _____ | | | | | | | | | 13 |
| 14 | TOTAL | | | \$ | 7,866 | \$ 117,999 | \$ 19,334 | 7,866 | \$ 137,333 | 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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

| | | 1 | 2 | |
|----|----------------------------------------------------------------------------------|--------------|----------------------|----|
| | | Operating | After Consolidation* | |
| | A. Current Assets | | | |
| 1 | Cash on Hand and in Banks | \$ (14,244) | \$ (14,244) | 1 |
| 2 | Cash-Patient Deposits | 39,520 | 39,520 | 2 |
| 3 | Accounts & Short-Term Notes Receivable-Patients (less allowance <u>155,062</u>) | 1,210,188 | 1,210,188 | 3 |
| 4 | Supply Inventory (priced at <u>Cost</u>) | 13,727 | 13,727 | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 27,241 | 27,241 | 6 |
| 7 | Other Prepaid Expenses | 473 | 473 | 7 |
| 8 | Accounts Receivable (owners or related parties) | | | 8 |
| 9 | Other(specify): <u>Prepaid Expenses</u> | | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 1,276,905 | \$ 1,276,905 | 10 |
| | B. Long-Term Assets | | | |
| 11 | Long-Term Notes Receivable | | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | 67,073 | 13,500 | 13 |
| 14 | Buildings, at Historical Cost | 2,842,209 | 1,068,665 | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 509,932 | 2,350,593 | 15 |
| 16 | Equipment, at Historical Cost | 1,204,230 | 1,204,230 | 16 |
| 17 | Accumulated Depreciation (book methods) | (3,778,709) | (3,954,743) | 17 |
| 18 | Deferred Charges | | | 18 |
| 19 | Organization & Pre-Operating Costs | 443,042 | 443,042 | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | (215,598) | (215,598) | 20 |
| 21 | Restricted Funds | | | 21 |
| 22 | Other Long-Term Assets (specify): | | | 22 |
| 23 | Other(specify): <u>Escrows and Reserves</u> | 402,119 | 402,119 | 23 |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | \$ 1,474,298 | \$ 1,311,808 | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 2,751,203 | \$ 2,588,713 | 25 |

| | | 1 | 2 | |
|----|--------------------------------------------------------------|----------------|----------------------|----|
| | | Operating | After Consolidation* | |
| | C. Current Liabilities | | | |
| 26 | Accounts Payable | \$ 695,350 | \$ 695,350 | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | 39,520 | 39,520 | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | 113,913 | 113,913 | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes) | 23,719 | 23,719 | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | | | 32 |
| 33 | Accrued Interest Payable | 71,651 | 71,651 | 33 |
| 34 | Deferred Compensation | | | 34 |
| 35 | Federal and State Income Taxes | 21,984 | 21,984 | 35 |
| | Other Current Liabilities(specify): | | | |
| 36 | <u>Payroll Withholdings</u> | 2,651 | 2,651 | 36 |
| 37 | <u>Accrued Management Fees</u> | 1,258,000 | 1,258,000 | 37 |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | \$ 2,226,788 | \$ 2,226,788 | 38 |
| | D. Long-Term Liabilities | | | |
| 39 | Long-Term Notes Payable | | | 39 |
| 40 | Mortgage Payable | 2,796,175 | 2,796,175 | 40 |
| 41 | Bonds Payable | | | 41 |
| 42 | Deferred Compensation | | | 42 |
| | Other Long-Term Liabilities(specify): | | | |
| 43 | <u>Intercompany Loans</u> | 351,000 | 351,000 | 43 |
| 44 | | | | 44 |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | \$ 3,147,175 | \$ 3,147,175 | 45 |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | \$ 5,373,963 | \$ 5,373,963 | 46 |
| 47 | TOTAL EQUITY(page 18, line 24) | \$ (2,622,760) | \$ (2,785,250) | 47 |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | \$ 2,751,203 | \$ 2,588,713 | 48 |

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

| | | 1 Total | |
|-----------|---------------------------------------------------------------------|-----------------------|-------------|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ (3,147,198) | 1 |
| 2 | Restatements (describe): | | 2 |
| 3 | Adjustments Made After Cost Report Was Filed | 624,831 | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ (2,522,367) | 6 |
| | A. Additions (deductions): | | |
| 7 | NET Income (Loss) (from page 19, line 43) | (100,393) | 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) | \$ (100,393) | 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) | \$ (2,622,760) | 24 * |

* This must agree with page 17, line 47.

Facility Name & ID Number **Prairie Rose Health Care Center**# **0045245**Report Period Beginning: **1/1/2017**Ending: **12/31/2017****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**

| I. Revenue | | Amount | |
|----------------------------------------|-----------------------------------------------------------|--------------|-----|
| A. Inpatient Care | | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 2,526,467 | 1 |
| 2 | Discounts and Allowances for all Levels | (128,458) | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 2,398,009 | 3 |
| B. Ancillary Revenue | | | |
| 4 | Day Care | | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | 219,915 | 6 |
| 7 | Oxygen | 1,210 | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 221,125 | 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 | 6,090 | 14 |
| 15 | Telephone, Television and Radio | | 15 |
| 16 | Rental of Facility Space | | 16 |
| 17 | Sale of Drugs | 63,454 | 17 |
| 18 | Sale of Supplies to Non-Patients | | 18 |
| 19 | Laboratory | | 19 |
| 20 | Radiology and X-Ray | 5,796 | 20 |
| 21 | Other Medical Services | 24,197 | 21 |
| 22 | Laundry | 58 | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 99,595 | 23 |
| D. Non-Operating Revenue | | | |
| 24 | Contributions | | 24 |
| 25 | Interest and Other Investment Income*** | 495 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 495 | 26 |
| E. Other Revenue (specify):**** | | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | <u>Transportation Revenue</u> | 134 | 28 |
| 28a | <u>Miscellaneous Revenue</u> | 116,295 | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ 116,429 | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 2,835,653 | 30 |

| II. Expenses | | Amount | |
|-------------------------------------|----------------------------------------------------------------|--------------|----|
| A. Operating Expenses | | | |
| 31 | General Services | 635,202 | 31 |
| 32 | Health Care | 1,198,349 | 32 |
| 33 | General Administration | 527,072 | 33 |
| B. Capital Expense | | | |
| 34 | Ownership | 345,737 | 34 |
| C. Ancillary Expense | | | |
| 35 | Special Cost Centers | 68,780 | 35 |
| 36 | Provider Participation Fee | 160,906 | 36 |
| D. Other Expenses (specify): | | | |
| 37 | | | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 2,936,046 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | (100,393) | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ (100,393) | 43 |

| III. Net Inpatient Revenue detailed by Payer Source | | Amount | |
|-----------------------------------------------------|-----------------------------------------------------------------------|--------------|----|
| 44 | Medicaid - Net Inpatient Revenue | \$ 1,999,054 | 44 |
| 45 | Private Pay - Net Inpatient Revenue | 243,841 | 45 |
| 46 | Medicare - Net Inpatient Revenue | 150,342 | 46 |
| 47 | Other-(specify) <u>Insurance Net Inpatient Revenue</u> | 4,772 | 47 |
| 48 | Other-(specify) | | 48 |
| 49 | TOTAL Inpatient Care Revenue (This total must agree to Line 3) | \$ 2,398,009 | 49 |

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Rose Health Care Center

0045245

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

| | 1 | 2** | 3 | 4 | | |
|----|---------------------------------|----------------------------|----------------------------------------|---------------------|----------|----|
| | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage | | |
| 1 | Director of Nursing | 2,675 | 2,739 | \$ 65,954 | \$ 24.08 | 1 |
| 2 | Assistant Director of Nursing | | | | | 2 |
| 3 | Registered Nurses | 1,430 | 1,430 | 31,316 | 21.90 | 3 |
| 4 | Licensed Practical Nurses | 16,047 | 16,941 | 325,086 | 19.19 | 4 |
| 5 | CNAs & Orderlies | 32,137 | 32,786 | 445,013 | 13.57 | 5 |
| 6 | CNA Trainees | | | | | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | | | | | 8 |
| 9 | Activity Director | 1,947 | 1,994 | 22,725 | 11.40 | 9 |
| 10 | Activity Assistants | 855 | 855 | 7,370 | 8.62 | 10 |
| 11 | Social Service Workers | 2,066 | 2,093 | 40,757 | 19.47 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | 1,540 | 1,672 | 24,705 | 14.78 | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 11,528 | 11,988 | 116,659 | 9.73 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 1,984 | 2,110 | 38,003 | 18.01 | 17 |
| 18 | Housekeepers | 11,305 | 11,837 | 129,593 | 10.95 | 18 |
| 19 | Laundry | 1,699 | 1,849 | 18,480 | 9.99 | 19 |
| 20 | Administrator | 2,080 | 2,080 | 76,742 | 36.90 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | 1,732 | 1,732 | 23,603 | 13.63 | 23 |
| 24 | Clerical | | | | | 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 | | | | | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| 33 | Other(specify) <u>See PG20A</u> | 1,720 | 1,664 | 32,835 | 19.73 | 33 |
| 34 | TOTAL (lines 1 - 33) | 90,745 | 93,770 | \$ 1,398,841 * | \$ 14.92 | 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 | \$ | | 35 |
| 36 | Medical Director | Monthly 21,000 | L9,C3 | 36 |
| 37 | Medical Records Consultant | | | 37 |
| 38 | Nurse Consultant | | | 38 |
| 39 | Pharmacist Consultant | Monthly 4,886 | L10, C3 | 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 | | | 45 |
| 46 | Other(specify) | | | 46 |
| 47 | | | | 47 |
| 48 | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | \$ 25,886 | | 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 |

Prairie Rose Health Care Center

0045245

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 20A

XVIII. Staffing and Salary Costs

| | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage |
|-----------------------|---------------------------------|----------------------------------|----------------------------------------------------|---------------------------|
| Care Plan Coordinator | 1,149 | 1,093 | 23,785 | 21.76 |
| Transportation | 220 | 220 | 2,198 | 9.99 |
| Marketing | 351 | 351 | 6,852 | 19.52 |
| TOTAL | 1,720 | 1,664 | 32,835 | |

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 | |
| Shannon Moore | Administrator | 0 | \$ 74,034 | Workers' Compensation Insurance | \$ 40,308 | IDPH License Fee | \$ 3,980 | |
| Ashlie Schmitz | Administrator | 0 | 2,708 | Unemployment Compensation Insurance | 20,553 | Advertising: Employee Recruitment | 321 | |
| | | | | FICA Taxes | 94,156 | Health Care Worker Background Check (Indicate # of checks performed <u>82</u>) | 583 | |
| | | | | Employee Health Insurance | 733 | Miscellaneous Licenses & Permits | 560 | |
| | | | | Employee Meals | | Miscellaneous Dues & Subscriptions | 1,113 | |
| | | | | Illinois Municipal Retirement Fund (IMRF)* | | | | |
| | | | | Employee Relations | 1,267 | | | |
| | | | | Employee Retirement | 1,391 | | | |
| TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) | | | \$ 76,742 | TOTAL (agree to Schedule V, line 22, col.8) | | \$ 6,432 | | |
| B. Administrative - Other | | | | | | | Less: Public Relations Expense (125) | |
| Description | | | Amount | | | | Non-allowable advertising () | |
| Management Fees | | | \$ 173,958 | | | | Yellow page advertising () | |
| TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) | | | \$ 173,958 | E. Schedule of Non-Cash Compensation Paid to Owners or Employees | | | G. Schedule of Travel and Seminar** | |
| C. Professional Services | | | | Description | | | Description | |
| Vendor/Payee | Type | Amount | | Line # | Amount | Amount | | |
| Ginoli & Company | Accounting Services | \$ 10,295 | | | | Out-of-State Travel \$ | | |
| Consolidated Communications | Computer Services | 951 | | | | | | |
| Allscripts | Computer Services | 888 | | | | In-State Travel | | |
| Ability Network | Computer Services | 4,567 | | N/A | | | | |
| ProTitle USA | Legal Fees | 138 | | | | Seminar Expense | | |
| TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions) | | | \$ 16,839 | TOTAL | | \$ | | |
| | | | | | | | Entertainment Expense () | |
| | | | | | | | TOTAL (agree to Sch. V, line 24, col. 8) \$ | |

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Rose Health Care Center# 0045245

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$952
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,390 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 160,906
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? Yes Indicate the amount. \$ 6,090
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 134
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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? Yes
Firm Name: Ginoli and Company
- (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. No
Attach invoices and a summary of services for all architect and appraisal fees