

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,684	2,124	3,599	26,407	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,684	2,124	3,599	26,407	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.42%

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

0 (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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 05/01/97

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

YES Date 05/01/97 NO

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

YES NO If YES, enter number of beds certified 53 and days of care provided 2,711

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	154,654	16,335	8,439	179,428		179,428	97	179,525		1
2	Food Purchase		179,633		179,633		179,633	(1,720)	177,913		2
3	Housekeeping	96,485	17,788		114,273		114,273	588	114,861		3
4	Laundry	42,108	13,978		56,086		56,086		56,086		4
5	Heat and Other Utilities			104,678	104,678		104,678	729	105,407		5
6	Maintenance	77,168	234	97,501	174,903		174,903	6,315	181,218		6
7	Other (specify):* See Supplemental	14,365		750	15,115		15,115	399	15,514		7
8	TOTAL General Services	384,780	227,968	211,368	824,116		824,116	6,408	830,524		8
	B. Health Care and Programs										
9	Medical Director			22,500	22,500		22,500		22,500		9
10	Nursing and Medical Records	1,384,489	115,782	2,959	1,503,230		1,503,230		1,503,230		10
10a	Therapy	35,952			35,952		35,952		35,952		10a
11	Activities	42,402	13,195	957	56,554		56,554		56,554		11
12	Social Services	43,170		16,023	59,193		59,193		59,193		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,506,013	128,977	42,439	1,677,429		1,677,429		1,677,429		16
	C. General Administration										
17	Administrative	139,576			139,576		139,576	10,140	149,716		17
18	Directors Fees										18
19	Professional Services			213,328	213,328		213,328	(136,334)	76,994		19
20	Dues, Fees, Subscriptions & Promotions			29,254	29,254		29,254	(4,154)	25,100		20
21	Clerical & General Office Expenses	116,330	5,253	558,248	679,831		679,831	(481,081)	198,750		21
22	Employee Benefits & Payroll Taxes			428,928	428,928		428,928	(6,633)	422,295		22
23	Inservice Training & Education			692	692		692		692		23
24	Travel and Seminar			1,610	1,610		1,610	19	1,629		24
25	Other Admin. Staff Transportation			31,925	31,925		31,925	487	32,412		25
26	Insurance-Prop.Liab.Malpractice			146,076	146,076		146,076	9,620	155,696		26
27	Other (specify):* See Supplemental							13,290	13,290		27
28	TOTAL General Administration	255,906	5,253	1,410,061	1,671,220		1,671,220	(594,646)	1,076,574		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,146,699	362,198	1,663,868	4,172,765		4,172,765	(588,238)	3,584,527		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	14,365		750	15,115
				-
Alloc - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			399	399
				-
				-
				-
Sub-Total	<u>14,365</u>	<u>-</u>	<u>1,149</u>	<u>15,514</u>
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 27 - Other General Administration				
Alloc - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			13,290	13,290
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>13,290</u>	<u>13,290</u>

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

#0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

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			34,969	34,969		34,969	86,533	121,502			30
31	Amortization of Pre-Op. & Org.			882	882		882	(882)				31
32	Interest			87,628	87,628		87,628	78,005	165,633			32
33	Real Estate Taxes							28,001	28,001			33
34	Rent-Facility & Grounds			237,900	237,900		237,900	(237,900)				34
35	Rent-Equipment & Vehicles			9,491	9,491		9,491	538	10,029			35
36	Other (specify):* See Supplemental							12,384	12,384			36
37	TOTAL Ownership			370,870	370,870		370,870	(33,321)	337,549			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		193,189	645,288	838,477		838,477	(192,671)	645,806			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,211	211,211		211,211		211,211			42
43	Other (specify):* See Supplemental	157,304			157,304		157,304	(157,304)				43
44	TOTAL Special Cost Centers	157,304	193,189	856,499	1,206,992		1,206,992	(349,975)	857,017			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,304,003	555,387	2,891,237	5,750,627		5,750,627	(971,534)	4,779,093			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
Prairie Village Healthcare Center, LLC				-
Mortgage Insurance Premiums			12,384	12,384
				-
				-
				-
				-
				-
Sub-Total	-	-	12,384	12,384

Line 43 - Other Special Cost Centers				
Non-Allowable	157,304			157,304
				-
				-
				-
				-
				-
				-
Sub-Total	157,304	-	-	157,304

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(701)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,004)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(504,754)	21		24
25	Fund Raising, Advertising and Promotional	(4,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(422,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (934,206)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,328)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (37,328)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (971,534)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Healthcare Center, Inc.

ID# 0042671
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy Settlements	\$ (192,671)	39	1
2	Legal Expense - Non Allowable	(12,730)	19	2
3	Professional Fees - Non Allowable	(5,535)	19	3
4	Theft	(342)	21	4
5	Settlements	(29,838)	21	5
6	Bank Fees	(4,493)	21	6
7	Amortization	(882)	31	7
8	Non-Allowable	(157,304)	43	8
9				9
10	Prairie Village Healthcare Center, LLC			10
11	Professional Fees	(15,250)	19	11
12	Office	(317)	21	12
13	Amortization	(2,794)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(422,156)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Village Healthcare Center, Inc.# 0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	97	0	0	0	0	0	0	0	0	97	1
2	Food Purchase	(2,004)	0	284	0	0	0	0	0	0	0	0	(1,720)	2
3	Housekeeping	0	0	588	0	0	0	0	0	0	0	0	588	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	729	0	0	0	0	0	0	0	0	729	5
6	Maintenance	0	0	2,008	4,307	0	0	0	0	0	0	0	6,315	6
7	Other (specify):*	0	0	0	399	0	0	0	0	0	0	0	399	7
8	TOTAL General Services	(2,004)	0	3,706	4,706	0	6,408	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	1,502	8,638	0	0	0	0	0	0	0	10,140	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,515)	15,250	(118,069)	0	0	0	0	0	0	0	0	(136,334)	19
20	Fees, Subscriptions & Promotions	(4,591)	0	437	0	0	0	0	0	0	0	0	(4,154)	20
21	Clerical & General Office Expenses	(539,744)	317	4,317	54,029	0	0	0	0	0	0	0	(481,081)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(6,633)	0	0	0	0	0	0	0	(6,633)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	19	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	0	0	487	0	0	0	0	0	0	0	0	487	25
26	Insurance-Prop.Liab.Malpractice	0	8,741	879	0	0	0	0	0	0	0	0	9,620	26
27	Other (specify):*	0	0	0	13,290	0	0	0	0	0	0	0	13,290	27
28	TOTAL General Administration	(577,850)	24,308	(110,428)	69,324	0	(594,646)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(579,854)	24,308	(106,722)	74,030	0	(588,238)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Village Healthcare Center, Inc.# 0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	85,284	1,249	0	0	0	0	0	0	0	0	86,533	30
31	Amortization of Pre-Op. & Org.	(3,676)	2,794	0	0	0	0	0	0	0	0	0	(882)	31
32	Interest	(701)	70,881	7,825	0	0	0	0	0	0	0	0	78,005	32
33	Real Estate Taxes	0	25,805	2,196	0	0	0	0	0	0	0	0	28,001	33
34	Rent-Facility & Grounds	0	(237,900)	0	0	0	0	0	0	0	0	0	(237,900)	34
35	Rent-Equipment & Vehicles	0	0	538	0	0	0	0	0	0	0	0	538	35
36	Other (specify):*	0	12,384	0	0	0	0	0	0	0	0	0	12,384	36
37	TOTAL Ownership	(4,377)	(40,752)	11,808	0	0	0	0	0	0	0	0	(33,321)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(192,671)	0	0	0	0	0	0	0	0	0	0	(192,671)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(157,304)	0	0	0	0	0	0	0	0	0	0	(157,304)	43
44	TOTAL Special Cost Centers	(349,975)	0	0	0	0	0	0	0	0	0	0	(349,975)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(934,206)	(16,444)	(94,914)	74,030	0	(971,534)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34	Rent	\$ 237,900	Prairie Village Healthcare Center, LLC	100.00%	\$	\$(237,900)	1
2	V	32	Interest	52	Prairie Village Healthcare Center, LLC	100.00%		(52)	2
3	V	19	Professional Fees		Prairie Village Healthcare Center, LLC	100.00%	15,250	15,250	3
4	V	21	Office		Prairie Village Healthcare Center, LLC	100.00%	317	317	4
5	V	26	Property Insurance		Prairie Village Healthcare Center, LLC	100.00%	8,741	8,741	5
6	V	30	Depreciation		Prairie Village Healthcare Center, LLC	100.00%	85,284	85,284	6
7	V	31	Amortization		Prairie Village Healthcare Center, LLC	100.00%	2,794	2,794	7
8	V	32	Interest		Prairie Village Healthcare Center, LLC	100.00%	70,933	70,933	8
9	V	33	Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	25,805	25,805	9
10	V	36	Mortgage Insurance Premiums		Prairie Village Healthcare Center, LLC	100.00%	12,384	12,384	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 237,952				\$ 221,508	\$ * (16,444)	14

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

Facility Name & ID Number

Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sherwin Ray	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Health Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	Prairie Village			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Healthcare CTR	Jacksonville, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

Facility Name & ID Number

Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 97	\$ 97	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	284	284	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	588	588	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	729	729	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,008	2,008	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,502	1,502	20
21	V	19 Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	1,931	(118,069)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	437	437	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	4,317	4,317	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	19	19	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	487	487	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	879	879	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,249	1,249	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	7,825	7,825	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,196	2,196	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	538	538	30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 120,000			\$ 25,086	\$ * (94,914)	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	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 4,307	\$	4,307	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0			16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	399		399	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0			18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,638		8,638	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	54,029		54,029	20
21	V	21 Office and Clerical (Direct)	13,902	Extended Care Consulting, LLC	100.00%	13,902			21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,109		12,109	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,181		1,181	23
24	V	22 Employee Benefits	6,633	Extended Care Consulting, LLC	100.00%			(6,633)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 20,535			\$ 94,565	\$ *	74,030	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	22 Employee Benefits	\$ 132,781	CCS VEBA	100.00%	\$ 132,781	\$	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		\$ 132,781			\$ 132,781	\$ *	39

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

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Sherwin Ray	Shareholder	Administration	33.33%	See Supplemental	7.63	19.08%	Salary	\$ 38,170	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	0.59	1.47%	Alloc. Salary	1,020	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 39,190		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation		Alloc. Compensation	
				Salary	Emp. Benefits	Salary	Emp. Benefits
Owners / Director Compensation							
Sherwin Ray						-	-
Timber Point Healthcare Center	7.63	40.00	19.08%	200,000	-	38,170	-
Prairie Village Healthcare Center	7.63	40.00	19.08%	200,000	-	38,170	-
Countryside Nursing & Rehab	18.13	40.00	45.33%	200,000	-	90,651	-
Rushville Nursing & Rehab	6.60	40.00	16.50%	200,000	-	33,010	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
Total	<u>40</u>		<u>100.00%</u>			<u>200,000</u>	<u>-</u>

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 Prairie Village Healthcare Center, LLC
 Street Address 1024 West Walnut
 City / State / Zip Code Jacksonville, Illinois 62650
 Phone Number (217) 245 - 5175
 Fax Number (217) 243 - 4276

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,476,506	37	\$ 5,451	\$ 26,407	\$ 97	1
2	2	Food	Patient Days	1,476,506	37	15,903	26,407	284	2
3	3	Housekeeping	Patient Days	1,476,506	37	32,901	26,407	588	3
4	5	Utilities	Patient Days	1,476,506	37	40,755	26,407	729	4
5	6	Maintenance	Patient Days	1,476,506	37	112,249	26,407	2,008	5
6	17	Administrative	Patient Days	1,476,506	37	84,000	26,407	1,502	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994	26,407	1,931	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409	26,407	437	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371	26,407	4,317	9
10	24	Travel and Seminar	Patient Days	1,476,506	37	1,048	26,407	19	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239	26,407	487	11
12	26	Insurance	Patient Days	1,476,506	37	49,139	26,407	879	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861	26,407	1,249	13
14	32	Interest	Patient Days	1,476,506	37	437,528	26,407	7,825	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769	26,407	2,196	15
16	35	Rent - Equipment and Auto	Patient Days	1,476,506	37	30,092	26,407	538	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,402,709	\$	\$ 25,086	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 941 - 9565

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,476,506	37	\$ 240,841	\$ 240,841	26,407	\$ 4,307	1
2	6	Maintenance	Direct	358,056	37	358,056	358,056			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,476,506	37	22,330		26,407	399	3
4	7	Emp. Ben. - Gen. Serv.	Direct	51,193	37	51,193				4
5	17	Administrative	Patient Days	1,476,506	37	483,002	483,002	26,407	8,638	5
6	21	Office and Clerical	Patient Days	1,476,506	37	3,020,951	3,020,951	26,407	54,029	6
7	21	Office and Clerical	Direct	498,631	37	498,631	498,631	13,902	13,902	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,476,506	37	677,040		26,407	12,109	8
9	27	Emp. Gen. - Gen. Admin.	Direct	74,203	37	74,203		1,181	1,181	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					\$ 5,426,247	\$ 4,601,481		\$ 94,565	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CCS VEBA

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905 - 3000

Fax Number

(847) 491 - 9565

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocation	37	\$ 9,005,461	\$	132,781	\$ 132,781	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				\$ 9,005,461	\$		\$ 132,781	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		
					Original	Balance						
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										
A. Directly Facility Related												
Long-Term												
1	Cambridge Realty Capital		X	Mortgage	\$10,030.06	04/21/16	\$ 2,334,000	\$		3.1500%	\$ 70,933	1
2												2
3												3
4												4
5												5
Working Capital												
6	HFG		X	Line of Credit							85,395	6
7	Alloc. - Extended Care		X	Line of Credit							7,825	7
8			X	Auto Loan							2,233	8
9	TOTAL Facility Related				\$10,030.06		\$ 2,334,000	\$			\$ 166,386	9
B. Non-Facility Related*												
10												10
11												11
12	Interest Income		X								(701)	12
13	Interest Income		X								(52)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (753)	14
15	TOTALS (line 9+line14)						\$ 2,334,000	\$			\$ 165,633	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,384 Line # 36 - 03

* 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' PREPARATION REPORT

** 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 Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	8,686	1997	\$ 170,000	1
2	Alloc. - Ext. Care			9,945	2
3	TOTALS	8,686		\$ 179,945	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	126	1997		\$ 1,114,539	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Prairie Village Healthcare Center, Inc. (Operating Entity)									
10										10
11	Various		2002	4,490						11
12	Various		2003	13,083						12
13	Various		2004	5,343						13
14	Various		2005	4,475						14
15	Various		2006	13,021						15
16	Various		2007	7,421						16
17	Various		2009	11,377						17
18	Various		2010	7,607						18
19	Various		2011	9,432						19
20	Various		2012	25,784						20
21	Alarm System		2014	4,784						21
22	Fire Sprinkler Heads		2014	6,500						22
23	Rooftop Carrier AC		2014	8,924						23
24	Boiler and Pump		2015	15,677						24
25	Addition - Carpentry, Millwork, Steel, Drywall, Concrete, Roofing, Doors,									
26	Windows, Painting, Flooring, HVAC, Plumbing, Electrical, Fire Alarm,									
27	Partitions		2015	76,895						27
28	Security System		2016	4,080						28
29	Compressors		2016	18,788						29
30	Double Doors - Remove and Replace		2017	6,058						30
31	Electrical Panel - Tranfer Switch and Breakers		2017	10,213						31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 <u>Prairie Village Healthcare Center, LLC (Building Partnership)</u>		\$	\$		\$	\$	\$	37
38								38
39 <u>Various</u>	<u>1997</u>	<u>487,113</u>						39
40 <u>Various</u>	<u>1998</u>	<u>185,832</u>						40
41 <u>Various</u>	<u>1999</u>	<u>3,549</u>						41
42 <u>Various</u>	<u>2000</u>	<u>9,164</u>						42
43 <u>Various</u>	<u>2001</u>	<u>54,531</u>						43
44 <u>Various</u>	<u>2008</u>	<u>134,167</u>						44
45 <u>Various</u>	<u>2009</u>	<u>63,595</u>						45
46 <u>Various</u>	<u>2010</u>	<u>14,295</u>						46
47 <u>Addition - Carpentry, Millwork, Steel, Drywall, Concrete,</u>								47
48 <u>Roofing, Doors, Windows, Painting, Flooring, HVAC,</u>								48
49 <u>Plumbing, Electrical, Fire Alarm, Partitions, General</u>	<u>2014</u>	<u>699,700</u>						49
50 <u>Sprinkler System</u>	<u>2014</u>	<u>106,300</u>						50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,126,737	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie Village Healthcare Center, Inc.# 0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17**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		\$ 3,126,737	\$		\$	\$	\$	1
2									2
3	<u>Related Party Allocations - See Supplemental Schedules</u>								3
4									4
5	<u>Allocations - Extended Care Consulting, LLC</u>	2007	82						5
6	<u>Allocations - Extended Care Consulting, LLC</u>	2009	49						6
7	<u>Allocations - Extended Care Consulting, LLC</u>	2010	483						7
8	<u>Allocations - Extended Care Consulting, LLC</u>	2011	174						8
9	<u>Allocations - Extended Care Consulting, LLC</u>	2012	57						9
10	<u>Allocations - Extended Care Consulting, LLC</u>	2014	793						10
11	<u>Allocations - Extended Care Consulting, LLC</u>	2016	951						11
12	<u>Allocations - Extended Care Consulting, LLC</u>	2017							12
13									13
14	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	13,705						14
15	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	11,321						15
16	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2003	13,342						16
17	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2005	663						17
18	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2009	120						18
19	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2014	1,148						19
20	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2015	189						20
21	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2016	745						21
22	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2017	1,292						22
23									23
24	<u>Allocations - Extended Care Consulting, LLC / Dyer Building</u>	2007	4,292						24
25									25
26									26
27									27
28									28
29									29
30									30
31	<u>Depreciation - Prairie Village Healthcare Center, Inc.</u>			34,969		34,969		337,420	31
32	<u>Depreciation - Prairie Village Healthcare Center, LLC</u>			85,284		85,284		1,217,844	32
33	<u>Depreciation - Extended Care Consulting, LLC</u>			1,249		1,249		92,901	33
34	TOTAL (lines 1 thru 33)		\$ 3,176,143	\$ 121,502		\$ 121,502	\$	\$ 1,648,165	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	\$ 283,359	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental	127,565						74
75	TOTALS	\$ 410,924	\$	\$	\$		\$	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	Facility	Van	2015	\$ 58,932	\$	\$	\$		\$	76
77	Alloc. - Extended Care			3,228						77
78										78
79										79
80	TOTALS			\$ 62,160	\$	\$	\$		\$	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)	\$ 3,829,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,502	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,502	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,648,165	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	See Suppl.							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: \$ 10,029 Description: See Supplemental Schedule
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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	39 - 03	hrs	\$		\$ 296,954	\$		\$ 296,954	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			28,663			28,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			293,646			293,646	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				192,671		192,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					518		518	12
13	Other (specify): See Supplemental	39 - 03				26,025			26,025	13
14	TOTAL			\$		\$ 645,288	\$ 193,189		\$ 838,477	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie Village Healthcare Center, Inc.
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Salaries		Supplies		Other		Total
Therapy and Rehab Supplies			407				407
Orthotics and Prosthetics			111				111
Laboratory					12,286		12,286
Radiology					9,244		9,244
Ambulance					1,835		1,835
Hospital Tests					2,660		2,660
							-
							-
							-
							-
							-
							-
							-
							-
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							-
							-
							-
							-
Total	-		518		26,025		26,543

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17** (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	\$ 76,736	\$ 253,504	1
2	Cash-Patient Deposits	31,459	31,459	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>904,175</u>)	674,873	674,873	3
4	Supply Inventory (priced at <u>Cost / FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,841	51,134	6
7	Other Prepaid Expenses	4,461	4,461	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	3,150	112,121	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 827,520	\$ 1,127,552	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,114,539	14
15	Leasehold Improvements, at Historical Cost	238,726	1,996,972	15
16	Equipment, at Historical Cost	361,080	430,080	16
17	Accumulated Depreciation (book methods)	(337,420)	(1,555,264)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	1,817	79,111	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 264,203	\$ 2,235,438	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,091,723	\$ 3,362,990	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 196,045	\$ 196,045	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,726	26,726	28
29	Short-Term Notes Payable	2,509,870	2,509,870	29
30	Accrued Salaries Payable	122,169	122,169	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,161	6,161	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,752	32
33	Accrued Interest Payable		5,851	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	414,483	414,483	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,275,454	\$ 3,308,057	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	26,395	2,255,508	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 26,395	\$ 2,255,508	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,301,849	\$ 5,563,565	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,210,126)	\$ (2,200,575)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,091,723	\$ 3,362,990	48

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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Medicare Settlement	3,150		3,150
Escrow - MIP		4,385	4,385
Escrow - Insurance		4,423	4,423
Escrow - Real Estate Taxes		32,022	32,022
Escrow - Replacement Reserve		68,141	68,141
Sub-Total	<u>3,150</u>	<u>108,971</u>	<u>112,121</u>
Line 23 - Long Term Assets			
Financing Costs (Net of Amortization)	1,249	77,294	78,543
State Replacement Tax Benefit	568		568
			-
			-
			-
Sub-Total	<u>1,817</u>	<u>77,294</u>	<u>79,111</u>
Line 36 - Other Current Liability			
Due to Affiliated Entities	414,483		414,483
			-
			-
			-
			-
Sub-Total	<u>414,483</u>	<u>-</u>	<u>414,483</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,627,194)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,627,194)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(582,932)	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)	\$ (582,932)	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)	\$ (2,210,126)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,741,713	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,741,713	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	224,913	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 224,913	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	701	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 701	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	200,368	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 200,368	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,167,695	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	824,116	31
32	Health Care	1,677,429	32
33	General Administration	1,671,220	33
B. Capital Expense			
34	Ownership	370,870	34
C. Ancillary Expense			
35	Special Cost Centers	995,781	35
36	Provider Participation Fee	211,211	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,750,627	40
41	Income before Income Taxes (line 30 minus line 40)**	(582,932)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (582,932)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,635,307	44
45	Private Pay - Net Inpatient Revenue	276,805	45
46	Medicare - Net Inpatient Revenue	1,324,590	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	427,805	47
48	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	77,206	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,741,713	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

Prairie Village Healthcare Center, Inc.
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Page 19 Supplemental Schedule

Description		Amount		Total		
Pharmacy Settlement		200,368		200,368		
Total				<u>200,368</u>		<u>200,368</u>

Facility Name & ID Number Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,958	2,119	\$ 79,177	\$ 37.37	1
2	Assistant Director of Nursing	1,967	2,127	52,159	24.52	2
3	Registered Nurses	5,987	6,377	175,436	27.51	3
4	Licensed Practical Nurses	20,586	21,872	463,105	21.17	4
5	CNAs & Orderlies	37,439	39,128	500,532	12.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,306	2,505	35,952	14.35	8
9	Activity Director	1,925	2,037	21,948	10.77	9
10	Activity Assistants	2,254	2,392	20,454	8.55	10
11	Social Service Workers	2,026	2,190	43,170	19.71	11
12	Dietician					12
13	Food Service Supervisor	1,416	1,605	24,211	15.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,961	14,109	130,443	9.25	15
16	Dishwashers					16
17	Maintenance Workers	5,578	6,149	77,168	12.55	17
18	Housekeepers	9,873	10,706	96,485	9.01	18
19	Laundry	4,366	4,881	42,108	8.63	19
20	Administrator	1,978	2,117	101,178	47.79	20
21	Assistant Administrator					21
22	Other Administrative	293	295	38,398	130.16	22
23	Office Manager					23
24	Clerical	5,523	5,904	116,330	19.70	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	1,752	1,893	20,921	11.05	31
32	Other Health Care(specify)					32
33	Other(specify)	8,411	8,807	264,828	30.07	33
34	TOTAL (lines 1 - 33)	128,599	137,213	\$ 2,304,003 *	\$ 16.79	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 8,439	01 - 03	35
36	Medical Director	22,500	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,959	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	957	11 - 03	44
45	Social Service Consultant	1,023	12 - 03	45
46	Other(specify)			46
47	See Supplemental	15,000		47
48				48
49	TOTAL (lines 35 - 48)	\$ 50,878		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Jerri Springer</u>	<u>Administrator</u>	<u>0</u>	\$ <u>101,178</u>	<u>Workers' Compensation Insurance</u>	\$ <u>119,470</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Sherwin Ray</u>	<u>Administrator</u>	<u>33.33%</u>	<u>38,398</u>	<u>Unemployment Compensation Insurance</u>	<u>30,545</u>	<u>Advertising: Employee Recruitment</u>	<u>615</u>	
				<u>FICA Taxes</u>	<u>165,373</u>	<u>Health Care Worker Background Check</u>	<u>2,083</u>	
				<u>Employee Health Insurance</u>	<u>102,072</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>17,790</u>	
				<u>Other Employee Benefits</u>	<u>4,835</u>	<u>Licenses and Fees</u>	<u>2,185</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 139,576			<u>Advertising and Promotion</u>	<u>4,591</u>	
(List each licensed administrator separately.)						<u>Alloc. - Extended Care Consulting</u>	<u>437</u>	
B. Administrative - Other								
Description			Amount			<u>Less: Public Relations Expense</u>	()	
			\$			<u>Non-allowable advertising</u>	<u>(4,591)</u>	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 422,295	TOTAL (agree to Sch. V,	\$ 25,100	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
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
<u>Extended Care Consulting, LLC</u>	<u>Home Office</u>		\$ <u>120,000</u>			\$	<u>Out-of-State Travel</u>	\$
<u>Plante & Moran, PLLC</u>	<u>Accounting</u>		<u>24,000</u>					
<u>Personnel Planners, Inc.</u>	<u>Unemployment Consultant</u>		<u>1,414</u>					
<u>Falkenberg, Fiewger & Ives</u>	<u>Legal</u>		<u>1,461</u>				<u>In-State Travel</u>	
<u>Foley and Lardner</u>	<u>Legal</u>		<u>57</u>					
<u>Holly Turner, Esq.</u>	<u>Legal</u>		<u>2,786</u>					
<u>Much Shelist</u>	<u>Legal</u>		<u>95</u>					
<u>Ogletree, Deakins, Nash</u>	<u>Legal</u>		<u>2,885</u>				<u>Seminar Expense</u>	<u>1,610</u>
<u>Robbins, Salomon & Patt</u>	<u>Legal</u>		<u>2,700</u>				<u>Alloc. - Extended Care Consulting</u>	<u>19</u>
<u>Federal Insurance Co.</u>	<u>Legal</u>		<u>5,860</u>					
<u>Ability Network</u>	<u>Data Processing / IT</u>		<u>5,171</u>					
<u>See Supplemental Schedule</u>			<u>46,899</u>				<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 213,328	TOTAL		\$	TOTAL (agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)							line 24, col. 8)	\$ 1,629

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Prairie Village Healthcare Center, Inc.# 0042671

Report Period Beginning:

01/01/17Ending: 12/31/17**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. ICLTC - \$13,148
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,111 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. \$ 211,211
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. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT