

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

0042671 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	11,701	2,420	3,223	17,344	8
9	SNF/PED					9
10	ICF	8,223	48		8,271	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,924	2,468	3,223	25,615	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.70%

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 2,721

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: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	157,183	15,834	9,518	182,535		182,535	99	182,634		1
2	Food Purchase		182,379		182,379		182,379	(840)	181,539		2
3	Housekeeping	107,794	17,453		125,247		125,247	540	125,787		3
4	Laundry	27,224	14,842		42,066		42,066		42,066		4
5	Heat and Other Utilities			104,965	104,965		104,965	807	105,772		5
6	Maintenance	73,498		85,369	158,867		158,867	6,726	165,593		6
7	Other (specify):* See Supplemental	8,000		309	8,309		8,309	396	8,705		7
8	TOTAL General Services	373,699	230,508	200,161	804,368		804,368	7,728	812,096		8
	B. Health Care and Programs										
9	Medical Director			28,500	28,500		28,500		28,500		9
10	Nursing and Medical Records	1,382,244	81,276	21,093	1,484,613		1,484,613		1,484,613		10
10a	Therapy	38,370			38,370		38,370		38,370		10a
11	Activities	43,813	12,422	757	56,992		56,992		56,992		11
12	Social Services	37,489		6,856	44,345		44,345		44,345		12
13	CNA Training										13
14	Program Transportation	658			658		658		658		14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,502,574	93,698	57,206	1,653,478		1,653,478		1,653,478		16
	C. General Administration										
17	Administrative	147,250			147,250		147,250	9,664	156,914		17
18	Directors Fees										18
19	Professional Services			200,735	200,735		200,735	(125,203)	75,532		19
20	Dues, Fees, Subscriptions & Promotions			44,710	44,710		44,710	(8,779)	35,931		20
21	Clerical & General Office Expenses	147,949	3,635	629,414	780,998		780,998	(398,942)	382,056		21
22	Employee Benefits & Payroll Taxes			364,206	364,206		364,206	(4,073)	360,133		22
23	Inservice Training & Education			3,083	3,083		3,083		3,083		23
24	Travel and Seminar			587	587		587	188	775		24
25	Other Admin. Staff Transportation			34,249	34,249		34,249	499	34,748		25
26	Insurance-Prop.Liab.Malpractice			279,076	279,076		279,076	9,369	288,445		26
27	Other (specify):* See Supplemental							14,724	14,724		27
28	TOTAL General Administration	295,199	3,635	1,556,060	1,854,894		1,854,894	(502,553)	1,352,341		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,171,472	327,841	1,813,427	4,312,740		4,312,740	(494,825)	3,817,915		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
 01/01/18 - 12/31/18

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	8,000		309	8,309
Extended Care Consulting, LLC				-
Employee Benefits			396	396
				-
				-
				-
Sub-Total	<u>8,000</u>	<u>-</u>	<u>705</u>	<u>8,705</u>
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 27 - Other General Administration				
Extended Care Consulting, LLC				-
Employee Benefits			14,724	14,724
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>14,724</u>	<u>14,724</u>

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

#0042671

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			36,464	36,464		36,464	86,602	123,066			30
31	Amortization of Pre-Op. & Org.			882	882		882	(882)				31
32	Interest			1,489	1,489		1,489	80,151	81,640			32
33	Real Estate Taxes							39,757	39,757			33
34	Rent-Facility & Grounds			201,900	201,900		201,900	(201,900)				34
35	Rent-Equipment & Vehicles			11,877	11,877		11,877	248	12,125			35
36	Other (specify):* See Supplemental							12,109	12,109			36
37	TOTAL Ownership			252,612	252,612		252,612	16,085	268,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,413	492,856	602,269		602,269		602,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,977	208,977		208,977		208,977			42
43	Other (specify):* See Supplemental	82,662			82,662		82,662	(82,662)				43
44	TOTAL Special Cost Centers	82,662	109,413	701,833	893,908		893,908	(82,662)	811,246			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,254,134	437,254	2,767,872	5,459,260		5,459,260	(561,402)	4,897,858			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
 01/01/18 - 12/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
Prairie Village Health Care Center, LLC				-
Mortgage Insurance Premiums			12,109	12,109
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>12,109</u>	<u>12,109</u>
Line 43 - Other Special Cost Centers				
Non-Allowable	82,662			82,662
				-
				-
				-
				-
				-
Sub-Total	<u>82,662</u>	<u>-</u>	<u>-</u>	<u>82,662</u>

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	(450)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,042)	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	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(443,045)	21		24
25	Fund Raising, Advertising and Promotional	(9,271)	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	(132,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (586,703)		\$	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)	25,301		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,301		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (561,402)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	52

Prairie Village Healthcare Center, Inc.

ID# 0042671

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Professional	\$ (8,027)	19	1
2	Theft Loss	(36)	21	2
3	Settlements	(19,139)	21	3
4	Telephone	(28)	21	4
5	Amortization	(882)	31	5
6	Non-Allowable	(82,662)	43	6
7				7
8	Prairie Village Healthcare Center, LLC			8
9	Professional	(18,550)	19	9
10	Administration	(277)	21	10
11	Amortization	(2,794)	31	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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	(132,395)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	99	0	0	0	0	0	0	0	0	99	1
2	Food Purchase	(1,042)	0	202	0	0	0	0	0	0	0	0	(840)	2
3	Housekeeping	0	0	540	0	0	0	0	0	0	0	0	540	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	807	0	0	0	0	0	0	0	0	807	5
6	Maintenance	0	0	2,161	4,565	0	0	0	0	0	0	0	6,726	6
7	Other (specify):*	0	0	0	396	0	0	0	0	0	0	0	396	7
8	TOTAL General Services	(1,042)	0	3,809	4,961	0	7,728	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	774	8,890	0	0	0	0	0	0	0	9,664	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,577)	18,550	(117,176)	0	0	0	0	0	0	0	0	(125,203)	19
20	Fees, Subscriptions & Promotions	(9,771)	0	992	0	0	0	0	0	0	0	0	(8,779)	20
21	Clerical & General Office Expenses	(462,525)	277	5,093	58,213	0	0	0	0	0	0	0	(398,942)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,073)	0	0	0	0	0	0	0	(4,073)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	188	0	0	0	0	0	0	0	0	188	24
25	Other Admin. Staff Transportation	0	0	499	0	0	0	0	0	0	0	0	499	25
26	Insurance-Prop.Liab.Malpractice	0	8,462	907	0	0	0	0	0	0	0	0	9,369	26
27	Other (specify):*	0	0	0	14,724	0	0	0	0	0	0	0	14,724	27
28	TOTAL General Administration	(498,873)	27,289	(108,723)	77,754	0	(502,553)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(499,915)	27,289	(104,914)	82,715	0	(494,825)	29						

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,318	0	0	0	0	0	0	0	0	86,602	30
31	Amortization of Pre-Op. & Org.	(3,676)	2,794	0	0	0	0	0	0	0	0	0	(882)	31
32	Interest	(450)	69,296	11,305	0	0	0	0	0	0	0	0	80,151	32
33	Real Estate Taxes	0	37,478	2,279	0	0	0	0	0	0	0	0	39,757	33
34	Rent-Facility & Grounds	0	(201,900)	0	0	0	0	0	0	0	0	0	(201,900)	34
35	Rent-Equipment & Vehicles	0	0	248	0	0	0	0	0	0	0	0	248	35
36	Other (specify):*	0	12,109	0	0	0	0	0	0	0	0	0	12,109	36
37	TOTAL Ownership	(4,126)	5,061	15,150	0	0	0	0	0	0	0	0	16,085	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(82,662)	0	0	0	0	0	0	0	0	0	0	(82,662)	43
44	TOTAL Special Cost Centers	(82,662)	0	0	0	0	0	0	0	0	0	0	(82,662)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(586,703)	32,350	(89,764)	82,715	0	(561,402)	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	\$ 201,900	Prairie Village Healthcare Center, LLC	100.00%	\$	\$ (201,900)	1
2	V	32 Interest	57	Prairie Village Healthcare Center, LLC	100.00%		(57)	2
3	V	19 Professional Fees		Prairie Village Healthcare Center, LLC	100.00%	18,550	18,550	3
4	V	21 Office		Prairie Village Healthcare Center, LLC	100.00%	277	277	4
5	V	26 Property Insurance		Prairie Village Healthcare Center, LLC	100.00%	8,462	8,462	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%	69,353	69,353	8
9	V	33 Real Estate Taxes		Prairie Village Healthcare Center, LLC	100.00%	37,478	37,478	9
10	V	36 Mortgage Insurance Premiums		Prairie Village Healthcare Center, LLC	100.00%	12,109	12,109	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 201,957			\$ 234,307	\$ * 32,350	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 Halth 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Prairie Village Healthcare Center, Inc.

0042671

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			Naperville Manor	Naperville, IL				5
6			South Holland Manor	South Holland, IL				6
7			Westmont Manor	Westmont, IL				7
8			Wheaton Care Center	Wheaton, IL				8
9			Estates of Hyde Park	Hyde Park, IL				9
10			Major Hospital - Spring Mill	Merrillville, IN				10
11			Major Hospital - Spring Mill AL	Merrillville, IN				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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 99	\$	99	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	202		202	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	540		540	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	807		807	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,161		2,161	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	774		774	20
21	V	19 Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	2,824		(117,176)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	992		992	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	5,093		5,093	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	188		188	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	499		499	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	907		907	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,318		1,318	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	11,305		11,305	28
29	V	33 Real Estate Taxes	107	Extended Care Consulting, LLC	100.00%	2,386		2,279	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	248		248	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		\$ 120,107			\$ 30,343	\$ *	(89,764)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 4,565	\$	4,565	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%	396		396	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%	8,890		8,890	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	58,213		58,213	20
21	V	21 Office and Clerical (Direct)	16,149	Extended Care Consulting, LLC	100.00%	16,149			21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	13,419		13,419	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,305		1,305	23
24	V	22 Employee Benefits	4,073	Extended Care Consulting, LLC	100.00%			(4,073)	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		\$ 20,222			\$ 102,937	\$ *	82,715	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 156,218	CCS VEBA	100.00%	\$ 156,218	\$	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		\$ 156,218			\$ 156,218	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	9.31	23.27%	Salary	\$ 46,549	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	0.74	1.85%	Alloc. Salary	1,402	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	\$ 47,951		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
 01/01/18 - 12/31/18

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation		Alloc. Compensation		
				Salary	Mgmt. Fees	Salary	Mgmt. Fees	
Owners / Director Compensation								
Sherwin Ray							-	-
Timber Point Healthcare Center	9.31	40.00	23.27%	200,000	-		46,549	-
Prairie Village Healthcare Center	9.31	40.00	23.27%	200,000	-		46,549	-
Countryside Nursing & Rehab	14.08	40.00	35.20%	200,000	-		70,397	-
Rushville Nursing & Rehab	7.30	40.00	18.25%	200,000	-		36,505	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
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:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	1,389,746	40	\$ 5,386	\$ 25,615	\$ 99	1
2	2	Food	Patient Days	1,389,746	40	10,961	25,615	202	2
3	3	Housekeeping	Patient Days	1,389,746	40	29,295	25,615	540	3
4	5	Utilities	Patient Days	1,389,746	40	43,781	25,615	807	4
5	6	Maintenance	Patient Days	1,389,746	40	117,234	25,615	2,161	5
6	17	Administrative	Patient Days	1,389,746	40	42,000	25,615	774	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207	25,615	2,824	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847	25,615	992	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330	25,615	5,093	9
10	24	Travel and Seminar	Patient Days	1,389,746	40	10,217	25,615	188	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054	25,615	499	11
12	26	Insurance	Patient Days	1,389,746	40	49,193	25,615	907	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516	25,615	1,318	13
14	32	Interest	Patient Days	1,389,746	40	613,328	25,615	11,305	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471	25,615	2,386	15
16	35	Rent - Equipment and Auto	Patient Days	1,389,746	40	13,470	25,615	248	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,646,290	\$	\$ 30,343	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	1,389,746	40	\$ 247,664	\$ 247,664	25,615	\$ 4,565	1
2	6	Maintenance	Direct	357,298	40	357,298	357,298			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,389,746	40	21,482		25,615	396	3
4	7	Emp. Ben. - Gen. Serv.	Direct	47,140	40	47,140				4
5	17	Administrative	Patient Days	1,389,746	40	482,303	482,303	25,615	8,890	5
6	21	Office and Clerical	Patient Days	1,389,746	40	3,158,355	3,158,355	25,615	58,213	6
7	21	Office and Clerical	Direct	484,472	40	484,472	484,472	16,149	16,149	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,389,746	40	728,044		25,615	13,419	8
9	27	Emp. Gen. - Gen. Admin.	Direct	72,742	40	72,742		1,305	1,305	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					\$ 5,599,500	\$ 4,730,092		\$ 102,937	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocation	8,429,403	\$ 8,429,403	\$	156,218	\$ 156,218	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 8,429,403	\$		\$ 156,218	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie Village Healthcare Center, Inc. # 0042671 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Cambridge Realty Capital		X	Mortgage	\$10,030.06	04/21/16	\$ 2,334,000	\$ 2,178,239			\$ 69,353	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	Extended Care Cons., LLC											6				
7	Allocation		X	Line of Credit							11,305	7				
8			X	Auto Loan							1,489	8				
9	TOTAL Facility Related				\$10,030.06		\$ 2,334,000	\$ 2,178,239			\$ 82,147	9				
B. Non-Facility Related*																
10												10				
11												11				
12	Interest Income		X								(450)	12				
13	Interest Income		X								(57)	13				
14	TOTAL Non-Facility Related						\$	\$			\$ (507)	14				
15	TOTALS (line 9+line14)						\$ 2,334,000	\$ 2,178,239			\$ 81,640	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,109 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.)

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 2017 report.	\$	<u>26,752</u>	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.)	\$	<u>33,718</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>6,966</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>32,898</u>	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.)	\$	<u>147</u>	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.)	\$	<u>(254)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>39,757</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>24,128</u>	8
	2014	<u>24,900</u>	9
	2015	<u>25,167</u>	10
	2016	<u>25,478</u>	11
	2017	<u>31,332</u>	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

2018 Real Estate Tax Accrual = \$31,332 * 1.05 = \$32,898
Extended Care Consulting, LLC - RE Tax Allocation = \$2,386

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09 - 17 - 100 - 012</u>	<u>Long Term Care Facility</u>	\$ <u>31,331.52</u>	\$ <u>31,331.52</u>
2. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>129,470.54</u>	\$ <u>2,386.33</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>160,802.06</u></u>	\$ <u><u>33,717.85</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

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

0042671

Report Period Beginning:

01/01/18 Ending:

12/31/18

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	<u>Facility</u>	<u>8,686</u>	<u>1997</u>	<u>\$ 170,000</u>	1
2	<u>Alloc. - Ext. Care</u>			<u>10,249</u>	2
3	TOTALS	8,686		\$ 180,249	3

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	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	Various			2014	20,208						21
22	Boiler and Pump			2015	15,677						22
23	Addition - Carpentry, Millwork, Steel, Drywall, Concrete, Roofing, Doors,										
24	Windows, Painting, Flooring, HVAC, Plumbing, Electrical, Fire Alarm,										
25	Partitions			2015	76,895						25
26	Security System			2016	4,080						26
27	Compressors			2016	18,788						27
28	Double Doors - Remove and Replace			2017	6,058						28
29	Electrical Panel - Tranfer Switch and Breakers			2017	10,213						29
30	Water Heater			2018	6,477						30
31	Concrete Pad - Patio (Life Safety Code)			2018	4,000						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:

01/01/18

Ending:

12/31/18

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>Various</u>	<u>2014</u>	<u>806,000</u>						47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,137,214	\$		\$	\$	\$	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:

01/01/18

Ending:

12/31/18**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		\$ 3,137,214	\$		\$	\$	\$	1
2									2
3	<u>Related Party Allocations - See Supplemental Schedules</u>								3
4									4
5	<u>Allocations - Extended Care Consulting, LLC</u>	2007	85						5
6	<u>Allocations - Extended Care Consulting, LLC</u>	2009	51						6
7	<u>Allocations - Extended Care Consulting, LLC</u>	2010	497						7
8	<u>Allocations - Extended Care Consulting, LLC</u>	2011	179						8
9	<u>Allocations - Extended Care Consulting, LLC</u>	2012	59						9
10	<u>Allocations - Extended Care Consulting, LLC</u>	2014	817						10
11	<u>Allocations - Extended Care Consulting, LLC</u>	2016	980						11
12	<u>Allocations - Extended Care Consulting, LLC</u>	2017							12
13	<u>Allocations - Extended Care Consulting, LLC</u>	2018							13
14									14
15	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	14,124						15
16	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	11,667						16
17	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2003	13,749						17
18	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2005	683						18
19	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2009	123						19
20	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2014	1,183						20
21	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2015	194						21
22	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2016	768						22
23	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2017	1,332						23
24	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2018	610						24
25									25
26	<u>Allocations - Extended Care Consulting, LLC / Dyer Building</u>	2007	4,424						26
27									27
28									28
29	<u>Depreciation - Prairie Village Healthcare Center, Inc.</u>			36,464		36,464		373,884	29
30	<u>Depreciation - Prairie Village Healthcare Center, LLC</u>			85,284		85,284		1,303,127	30
31	<u>Depreciation - Extended Care Consulting, LLC</u>			647		647		56,455	31
32	<u>Depreciation - Extended Care Consulting, LLC / 2201 Main LLC</u>			573		573		36,631	32
33	<u>Depreciation - Extended Care Consulting, LLC / Dyer Building</u>			98		98		1,127	33
34	TOTAL (lines 1 thru 33)		\$ 3,188,739	\$ 123,066		\$ 123,066	\$	\$ 1,771,224	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 283,359	\$	\$	\$		\$	71
72	Current Year Purchases	3,338						72
73	Fully Depreciated Assets							73
74	See Supplemental	129,355						74
75	TOTALS	\$ 416,052	\$	\$	\$		\$	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	Ext. Care Consult., LLC			469						77
78										78
79										79
80	TOTALS			\$ 59,401	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,844,441 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,066 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,066 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)	\$ 1,771,224 85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

**

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: \$ 12,125 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

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. _____/2019 \$ _____

13. _____/2020 \$ _____

14. _____/2021 \$ _____

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' 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	\$		\$ 240,053	\$		\$ 240,053	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			20,726			20,726	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			212,827			212,827	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				109,204		109,204	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					209		209	12
13	Other (specify): See Supplemental	39 - 03				19,250			19,250	13
14	TOTAL			\$		\$ 492,856	\$ 109,413		\$ 602,269	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

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

0042671

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(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	\$ 150,499	\$ 326,140	1
2	Cash-Patient Deposits	26,292	26,292	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>924,927</u>)	881,367	881,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,046	27,046	6
7	Other Prepaid Expenses	6,616	20,808	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>		121,068	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,091,820	\$ 1,402,721	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	249,203	2,007,449	15
16	Equipment, at Historical Cost	364,416	433,416	16
17	Accumulated Depreciation (book methods)	(373,884)	(1,677,011)	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>	935	75,435	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 240,670	\$ 2,123,828	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,332,490	\$ 3,526,549	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 665,875	\$ 665,875	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,292	26,292	28
29	Short-Term Notes Payable	2,521,105	2,521,105	29
30	Accrued Salaries Payable	158,005	158,005	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,655	9,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32,898	32
33	Accrued Interest Payable		5,718	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	455,562	455,562	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,836,494	\$ 3,875,110	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	14,877	14,877	39
40	Mortgage Payable		2,178,239	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)	\$ 14,877	\$ 2,193,116	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,851,371	\$ 6,068,226	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,518,881)	\$ (2,541,677)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,332,490	\$ 3,526,549	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Prairie Village Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Escrow - MIP		5,353	5,353
Escrow - Insurance		4,827	4,827
Escrow - Real Estate Taxes		36,691	36,691
Escrow - Replacement Reserve		74,197	74,197
			-
Sub-Total	<u>-</u>	<u>121,068</u>	<u>121,068</u>
Line 23 - Long Term Assets			
Financing Fees (Net of Amortization)	935		935
Financing Fees (Net of Amortization)		74,500	74,500
			-
			-
			-
Sub-Total	<u>935</u>	<u>74,500</u>	<u>75,435</u>
Line 36 - Other Current Liability			
Due to Affiliated Entities	70,679		70,679
Due to Ownership	384,883		384,883
			-
			-
			-
Sub-Total	<u>455,562</u>	<u>-</u>	<u>455,562</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	\$ (2,210,126)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,210,126)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(308,755)	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)	\$ (308,755)	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)	\$ (2,518,881)	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	\$ 5,019,999	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,019,999	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,057	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,057	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***	449	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 449	26
E. Other Revenue (specify).****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,150,505	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	804,368	31
32	Health Care	1,653,478	32
33	General Administration	1,854,894	33
B. Capital Expense			
34	Ownership	252,612	34
C. Ancillary Expense			
35	Special Cost Centers	684,931	35
36	Provider Participation Fee	208,977	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,459,260	40
41	Income before Income Taxes (line 30 minus line 40)**	(308,755)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (308,755)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,783,829	44
45	Private Pay - Net Inpatient Revenue	506,598	45
46	Medicare - Net Inpatient Revenue	1,407,106	46
47	Other-(specify) Insurance - Net Inpatient Revenue	256,664	47
48	Other-(specify) Hospice - Net Inpatient Revenue	65,802	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,019,999	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

0042671

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,941	2,454	\$ 93,403	\$ 38.06	1
2	Assistant Director of Nursing	1,780	1,840	46,315	25.17	2
3	Registered Nurses	5,090	5,380	153,518	28.53	3
4	Licensed Practical Nurses	19,100	20,648	448,069	21.70	4
5	CNAs & Orderlies	36,925	38,645	536,274	13.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,258	2,482	38,370	15.46	8
9	Activity Director	1,927	2,190	23,493	10.73	9
10	Activity Assistants	2,325	2,401	20,320	8.46	10
11	Social Service Workers	1,938	2,110	37,489	17.77	11
12	Dietician					12
13	Food Service Supervisor	1,931	2,146	32,806	15.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,811	6,113	55,714	9.11	15
16	Dishwashers	6,991	7,566	68,663	9.08	16
17	Maintenance Workers	4,982	5,584	73,498	13.16	17
18	Housekeepers	10,855	11,690	107,794	9.22	18
19	Laundry	2,871	3,126	27,224	8.71	19
20	Administrator	1,973	2,105	100,701	47.84	20
21	Assistant Administrator					21
22	Other Administrative	484	484	46,549	96.18	22
23	Office Manager					23
24	Clerical	6,166	6,559	147,949	22.56	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	1,996	2,082	23,193	11.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,753	6,197	172,792	27.88	33
34	TOTAL (lines 1 - 33)	123,097	131,802	\$ 2,254,134 *	\$ 17.10	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	\$ 9,518	01 - 03	35
36	Medical Director	28,500	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,822	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	757	11 - 03	44
45	Social Service Consultant	6,856	12 - 03	45
46	Other(specify) <u>See Supplemental</u>	15,271		46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 66,724		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jerri Springer	Administrator	0	\$ 100,701	Workers' Compensation Insurance	\$ 63,693	IDPH License Fee	\$ 1,990		
Sherwin Ray	Administration	33.33	46,549	Unemployment Compensation Insurance	22,220	Advertising: Employee Recruitment	366		
				FICA Taxes	163,993	Health Care Worker Background Check	6,189		
				Employee Health Insurance	104,679	(Indicate # of checks performed)			
				Employee Meals		<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	2,046		
				Other Employee Benefits	5,548	Dues - Associations	19,902		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 147,250			Dues and Subscriptions	4,446		
(List each licensed administrator separately.)						Advertising and Promotion	9,271		
B. Administrative - Other						Extended Care Consulting, LLC	992		
Description			Amount			Less: Public Relations Expense	()		
			\$			Non-allowable advertising	(9,271)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 360,133	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 35,931
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Extended Care Consulting, LLC	Home Office		\$ 120,000				Out-of-State Travel	\$	
Plante & Moran, PLLC	Accounting		24,000						
Blymas	Accounting		3,788						
Personnel Planners, Inc.	Unemployment Consultant		1,427				In-State Travel		
Ability Network	Data Processing / IT Cons.		6,528						
National Datacare Corporation	Data Processing / IT Cons.		2,072						
Propay	Data Processing / IT Cons.		13,692						
Matrixcare	Data Processing / IT Cons.		11,105				Seminar Expense	587	
Mediacom	Data Processing / IT Cons.		4,049				Extended Care Consulting, LLC	188	
Other	Data Processing / IT Cons.		3,025						
Other	Other Professional		3,022						
Other	Non-Allowable		8,027				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 200,735	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 775
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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 - \$19,902
- (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. \$ 6,530 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. \$ 208,977
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees