FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0046011

Facility Name: Prairie Manor Nrsg & Reh Ctr

Address: 345 Dixie Highway (Number) Chicago Heights (City) 60411 (Zip Code)

County: Cook

Telephone Number: (708) 754-7601 **Fax #** (708) 754-8904

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2002

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,020	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	148	TOTALS	148	54,020	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,202	4,164	12,570	47,936	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,202	4,164	12,570	47,936	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.74%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 148 and days of care provided 11,940

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,830	44,194	15,458	368,482		368,482	4,942	373,424			1
2	Food Purchase		290,426		290,426		290,426	447	290,873			2
3	Housekeeping	257,704	63,607		321,311		321,311	618	321,929			3
4	Laundry	86,633	20,532		107,165		107,165		107,165			4
5	Heat and Other Utilities			201,429	201,429		201,429	1,353	202,782			5
6	Maintenance	122,954		328,104	451,058		451,058	(118,601)	332,457			6
7	Other (specify):*							1,928	1,928			7
8	TOTAL General Services	776,121	418,759	544,991	1,739,871		1,739,871	(109,313)	1,630,558			8
	B. Health Care and Programs											
9	Medical Director			38,000	38,000		38,000		38,000			9
10	Nursing and Medical Records	3,216,446	312,855	9,069	3,538,370		3,538,370	43,920	3,582,290			10
10a	Therapy	274,418			274,418		274,418		274,418			10a
11	Activities	178,017	36,242		214,259		214,259		214,259			11
12	Social Services	254,095			254,095		254,095	19,978	274,073			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,315	7,315			15
16	TOTAL Health Care and Programs	3,922,976	349,097	47,069	4,319,142		4,319,142	71,213	4,390,355			16
	C. General Administration											
17	Administrative	162,392			162,392		162,392	90,399	252,791			17
18	Directors Fees											18
19	Professional Services			640,257	640,257	(3,416)	636,841	(516,333)	120,508			19
20	Dues, Fees, Subscriptions & Promotions			61,756	61,756		61,756	(23,971)	37,785			20
21	Clerical & General Office Expenses	176,672	63,940	191,696	432,308		432,308	(42,221)	390,087			21
22	Employee Benefits & Payroll Taxes			966,939	966,939		966,939	(2,091)	964,848			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,890	1,890		1,890	1,605	3,495			24
25	Other Admin. Staff Transportation			5,939	5,939		5,939	1,314	7,253			25
26	Insurance-Prop.Liab.Malpractice			220,050	220,050		220,050	1,945	221,995			26
27	Other (specify):*							33,478	33,478			27
28	TOTAL General Administration	339,064	63,940	2,088,527	2,491,531	(3,416)	2,488,115	(455,875)	2,032,240			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,038,161	831,796	2,680,587	8,550,544	(3,416)	8,547,128	(493,974)	8,053,154			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr #0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			116,862	116,862		116,862	139,870	256,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							131,351	131,351			32
33	Real Estate Taxes			577,665	577,665	3,416	581,081	3,015	584,096			33
34	Rent-Facility & Grounds			432,000	432,000		432,000	(432,000)				34
35	Rent-Equipment & Vehicles			3,837	3,837		3,837	772	4,609			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,130,364	1,130,364	3,416	1,133,780	(156,992)	976,788			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		840,927	1,582,641	2,423,568		2,423,568	(1,979)	2,421,589			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,978	298,978		298,978		298,978			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		840,927	1,881,619	2,722,546		2,722,546	(1,979)	2,720,567			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,038,161	1,672,723	5,692,570	12,403,454		12,403,454	(652,945)	11,750,509			45

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(30,157)	30		9
10	Interest and Other Investment Income	(73,756)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	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	(1,199)	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	(118,155)	21		24
25	Fund Raising, Advertising and Promotional	(17,109)	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	(217,931)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (458,554)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(194,391)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (194,391)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (652,945)		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 Yes	2 No	3 Amount	4 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

Prairie Manor Nrsg & Reh Ctr

ID# 0046011

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (55,263)	21	1
2	Jury Duty	(96)	10	2
3	Theft Loss	(1,875)	21	3
4	Collection Expense	(7,112)	21	4
5	Annual Report	(250)	20	5
6	Out of Period	(2,053)	21	6
7	PAC Dues	(7,377)	20	7
8	Non-allowable Legal	(8,890)	19	8
9	Additional R&M	4,075	06	9
10	Capitalized R&M	(136,151)	06	10
11	Building Company - Management Fees	(1,825)	21	11
12	Building Company - Miscellaneous Expense	(300)	21	12
13	Building Company - Filing Fee	(250)	21	13
14	Building Company - Amortization Expense	(564)	31	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**	(217,931)		49

Prairie Manor Nrsg & Reh Ctr

ID# 0046011

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary			155		4,787							4,942	1
2	Food Purchase	(248)		695									447	2
3	Housekeeping			520		98							618	3
4	Laundry													4
5	Heat and Other Utilities			1,173		180							1,353	5
6	Maintenance	(132,076)		4,841	8,486	148							(118,601)	6
7	Other (specify):*				1,382	546							1,928	7
8	**TOTAL General Services**	(132,324)		7,384	9,868	5,759							(109,313)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(96)				44,101				(85)			43,920	10
10a	Therapy													10a
11	Activities													11
12	Social Services					19,978							19,978	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,315							7,315	15
16	**TOTAL Health Care and Programs**	(96)				71,394				(85)			71,213	16
	C. General Administration													
17	Administrative			3,217	17,396	69,786							90,399	17
18	Directors Fees													18
19	Professional Services	(8,890)		(379,001)		(128,442)							(516,333)	19
20	Fees, Subscriptions & Promotions	(25,935)		1,709		255							(23,971)	20
21	Clerical & General Office Expenses	(186,833)	2,375	11,704	102,069	28,464							(42,221)	21
22	Employee Benefits & Payroll Taxes				(2,091)								(2,091)	22
23	Inservice Training & Education													23
24	Travel and Seminar			268		1,337							1,605	24
25	Other Admin. Staff Transportation			1,314									1,314	25
26	Insurance-Prop.Liab.Malpractice			1,412		533							1,945	26
27	Other (specify):*				22,431	11,047							33,478	27
28	**TOTAL General Administration**	(221,658)	2,375	(359,377)	139,805	(17,020)							(455,875)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(354,078)	2,375	(351,993)	149,673	60,133				(85)			(493,974)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(30,157)	164,417	4,353		1,257							139,870	30
31	Amortization of Pre-Op. & Org.	(564)	564											31
32	Interest	(73,756)	168,484	996		35,627							131,351	32
33	Real Estate Taxes			2,537		478							3,015	33
34	Rent-Facility & Grounds		(432,000)										(432,000)	34
35	Rent-Equipment & Vehicles			772									772	35
36	Other (specify):*													36
37	TOTAL Ownership	(104,477)	(98,535)	8,658		37,362							(156,992)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,979)						(1,979)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(1,979)						(1,979)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(458,554)	(96,160)	(343,335)	149,673	97,495	(1,979)			(85)			(652,945)	45

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 432,000	Prairie Manor Property, LLC	100.00%	$	$ (432,000)	1
2	V	32	Interest Income	20	Prairie Manor Property, LLC	100.00%		(20)	2
3	V	21	Management Fees		Prairie Manor Property, LLC	100.00%	1,825	1,825	3
4	V	21	Miscellaneous Expense		Prairie Manor Property, LLC	100.00%	300	300	4
5	V	21	Filing Fee		Prairie Manor Property, LLC	100.00%	250	250	5
6	V	30	Depreciation Expense		Prairie Manor Property, LLC	100.00%	164,417	164,417	6
7	V	31	Amortization Expense		Prairie Manor Property, LLC	100.00%	564	564	7
8	V	32	Interest Expense - Providence		Prairie Manor Property, LLC	100.00%	168,504	168,504	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 432,020			$ 335,860	$ * (96,160)	14

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 155	$ 155	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	695	695	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	520	520	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,173	1,173	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,841	4,841	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,217	3,217	20
21	V	19	Professional Fees	388,176	Extended Care Consulting, LLC	100.00%	9,175	(379,001)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,709	1,709	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,704	11,704	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	268	268	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,314	1,314	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,412	1,412	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	4,353	4,353	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	996	996	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,537	2,537	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	772	772	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			$ 388,176			$ 44,841	$ * (343,335)	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,342	$ 8,342	15
16	V	06	Maintenance (Direct)	4,670	Extended Care Consulting, LLC	100.00%	4,814	144	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	791	791	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	591	591	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,396	17,396	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	102,069	102,069	22
23	V	21	Office and Clerical (Direct)	1,677	Extended Care Consulting, LLC	100.00%	1,677		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,004	22,004	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	427	427	25
26	V	22	Employee Benefits	2,091	Extended Care Consulting, LLC	100.00%		(2,091)	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			$ 8,438			$ 158,111	$ * 149,673	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 98	$ 98	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	180	180	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	148	148	17
18	V	19	Professional Fees	129,396	Extended Care Clinical, LLC	100.00%	954	(128,442)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	255	255	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,472	1,472	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,337	1,337	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	533	533	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,257	1,257	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	35,627	35,627	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	478	478	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,787	4,787	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	546	546	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	44,101	44,101	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	19,978	19,978	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,315	7,315	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	69,786	69,786	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	26,992	26,992	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,047	11,047	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,396			$ 226,891	$ * 97,495	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Various Equipment	22,235	Vent Lease LLC	100.00%	20,256	$ (1,979)	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			$ 22,235			$ 20,256	$ * (1,979)	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 190,737	$ 190,737	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	190,737	CCS Employee Benefits Group	100.00%		(190,737)	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			$ 190,737			$ 190,737	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Expense	17,646	Care Centers Health Systems, Inc.	100.00%	17,646	$	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			$ 17,646			$ 17,646	$ *	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Supplies / Nursing Equip. Rental	300	Reliable Medical of the Midwest, LLC	100.00%	215	$ (85)	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			$ 300			$ 215	$ * (85)	39

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUM. TRUST	11.11 %	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	PRAIRIE MANOR PROPERTY, L	EVANSTON	BUILDING CO.	1
2	DANIEL ROTHNER ACCUM. TRUST	11.11 %	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	KATHRYN VALES ACCUM. TRUST	11.11 %	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	KIMBERLY RICHMAN ACCUM. TRUST	11.11 %	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5	MELISSA ROTHNER ACCUM. TRUST	11.11 %	GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	NATHAN & SHIRLEY ROTHNER TRUST	22.22 %	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	6
7	RACHEL ROTHNER ACCUM. TRUST	11.11 %	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	7
8	WILLIAM ROTHNER ACCUM. TRUST	11.11 %	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,251,572	31	$ 4,057	$	47,936	$ 155	1
2	02	Food	Patient Days	1,251,572	31	18,150		47,936	695	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		47,936	520	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		47,936	1,173	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		47,936	4,841	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		47,936	3,217	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		47,936	9,175	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		47,936	1,709	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		47,936	11,704	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		47,936	268	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		47,936	1,314	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		47,936	1,412	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		47,936	4,353	13
14	32	Interest	Patient Days	1,251,572	31	26,010		47,936	996	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		47,936	2,537	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		47,936	772	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 44,841	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	47,936	8,342	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		4,814	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		47,936	791	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			591	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	47,936	17,396	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	47,936	102,069	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		1,677	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		47,936	22,004	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			427	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					$ 4,662,721	$ 3,975,053		$ 158,111	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	758,409	19	$ 1,549	$	47,936	$ 98	1
2	05	Utilities	Patient Days	758,409	19	2,849		47,936	180	2
3	06	Maintenance	Patient Days	758,409	19	2,348		47,936	148	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		47,936	954	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		47,936	255	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		47,936	1,472	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		47,936	1,337	7
8	26	Insurance	Patient Days	758,409	19	8,431		47,936	533	8
9	30	Depreciation	Patient Days	758,409	19	19,889		47,936	1,257	9
10	32	Interest	Patient Days	758,409	19	563,670		47,936	35,627	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		47,936	478	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	47,936	4,787	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		47,936	546	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	47,936	44,101	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	47,936	19,978	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		47,936	7,315	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	47,936	69,786	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	47,936	26,992	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		47,936	11,047	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 226,891	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Various Equipment	Direct Allocation						20,256	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					$	$		$ 20,256	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 190,737	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					$	$		$ 190,737	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Expense	Direct Allocation						17,646	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					$	$		$ 17,646	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies / Nursing Equip	Direct Allocation						215	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					$	$		$ 215	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Providence Bank		X	Mortgage			$	$ 3,120,110			$ 168,504	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mattresses		X					84,116				6
7	Dell		X					23,302				7
8	See Supplemental Schedule										36,623	8
9	TOTAL Facility Related						$	$ 3,227,528			$ 205,127	9
	B. Non-Facility Related*											
10	Interest Income		X								(73,756)	10
11	Interest Income - Bldg. Co		X								(20)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (73,776)	14
15	TOTALS (line 9+line14)						$	$ 3,227,528			$ 131,351	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated - Ext. Care Consultin	X					$	$			$ 996	8
9	Allocated - Ext. Care Clinical	X									35,627	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										36,623	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 564,552	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.)		$ 560,188	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,364)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 585,032	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.)**		$ 3,416	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 584,084	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	535,700	8
2010	365,726	9
2011	512,458	10
2012	537,669	11
2013	557,173	12

2014 Accrual $557,173 x 1.05 = $585,032

Allocated - Extended Care Consulting $2,537

Allocated - Extended Care Clinical $478

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

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nrsg & Reh Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-17-131-007-0000	Long Term Care Property	$ 557,172.90	$ 557,172.90
2.	See Attached	Care Centers Building, LLC	$ 162,082.08	$ 2,871.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 719,254.98	$ 560,044.14

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nrsg & Reh Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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? _____ YES _____ NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2002	$ 450,000	1
2	Alloc - Care Centers Building / Ext. Care Clinical			14,526	2
3	TOTALS			$ 464,526	3

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	148			1988	$ 4,650,000	$ 164,417	39	$ 119,231	$ (45,186)	$ 1,421,817	4
5				2013	1,609,158		39	41,260	41,260	82,520	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	33,716		20	1,524	1,524	20,402	9
10	Various			2004	215,253		20	9,751	9,751	129,576	10
11	Various			2005	96,470		20	2,221	2,221	73,347	11
12	Various			2006	90,263		20	4,360	4,360	40,445	12
13	Various			2007	56,209		20	2,810	2,810	22,017	13
14	Various			2008	31,219		20	1,871	1,871	12,286	14
15	Various			2009	43,314		20	2,909	2,909	19,969	15
16	Various			2010	44,836		20	2,242	2,242	9,483	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		188,530			9,427	9,427	9,427	67
68	Related Party Allocations (Pages 12H & 12I)		63,481	4,009		4,009		43,924	68
69	Financial Statement Depreciation			116,862			(116,862)		69
70	TOTAL (lines 4 thru 69)		$ 7,122,449	$ 285,288		$ 201,615	$ (83,673)	$ 1,885,214	70

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,122,449	$ 285,288		$ 201,615	$ (83,673)	$ 1,885,214	1
2	23 New Doors	2011	17,500		20	875	875	3,208	2
3	Replace Staging Control For Chiller	2011	4,882		20	976	976	3,580	3
4	Drivit System On Exterior Walls	2011	59,310		20	2,966	2,966	9,885	4
5	Install Floor Alarm & Locks	2011	3,644		20	182	182	607	5
6	Modulating Flue Gas Inducer System	2011	5,651		20	283	283	918	6
7	Install New Hot Water Unit In Boiler Room	2011	8,800		20	440	440	1,357	7
8	Roof And Window Repair	2011	4,500		20	225	225	844	8
9	Replace Gypsum With Glass Boards	2012	29,840		20	1,492	1,492	4,476	9
10	Glass/Metal Store Front Construction	2012	20,465		20	1,023	1,023	2,899	10
11	Remove And Replace Concrete Slab In Dock Area	2012	10,500		20	525	525	1,138	11
12	Window Replacement	2012	2,850		20	143	143	416	12
13	Window Replacement	2012	2,850		20	143	143	404	13
14	Replace Concrete Slab - Handicap Ramp	2012	5,000		20	250	250	604	14
15	Boiler Modifications	2013	17,584		20	879	879	1,685	15
16	Sewer Repair	2013	2,555		20	128	128	245	16
17	Furnish & Install New Buffer Channel & Spring In Elevator	2013	37,400		20	1,870	1,870	2,961	17
18	Installed 2 New 200 Ampere Three Phase Three Wire 208 Volt Fee	2013	6,625		20	331	331	524	18
19	Installed Hot Water Coil And Pump Assembly	2014	15,382		20	769	769	769	19
20	Repair Heating System, Valve, Panel Guage, Thermostats, Transm	2014	4,215		20	773	773	773	20
21	Furnish And Install 4 Door Restrictors	2014	5,960		20	1,093	1,093	1,093	21
22	Replaced Cracked Coils On Air Unit	2014	41,310		20	1,893	1,893	1,893	22
23	Remove And Install 2 Mixing Valves	2014	4,439		20	203	203	203	23
24	Emergency Coil Repairs	2014	13,690		20	513	513	513	24
25	Furnish And Install 2 Faux Stucco Signs	2014	17,328		20	481	481	481	25
26	Replaced Actuator For Outside Air Damper For Air Handler	2014	9,149		20	38	38	38	26
27	Excavated And Repaired Leak On Auxiliary Valve On Fire Hydra	2014	3,250		20	163	163	163	27
28	Installed New Valves On Boiler	2014	3,933		20	197	197	197	28
29	Millwork, Patched Walls, Repaired Floors, Updated Plumbing,	2014	28,800		20	1,440	1,440	1,440	29
30	And Electric In Sitting Room & Beauty Salon	2014			20				30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,509,862	$ 285,288		$ 221,908	$ (63,380)	$ 1,928,528	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Reception Area/Meeting Room - Ceilings, Wood Trim, Doors	2014	188,530		20	9,427	9,427	9,427	9
10	Carpet Tile, Plumbing and Electrical								10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 188,530	$		$ 9,427	$ 9,427	$ 9,427	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 188,530	$		$ 9,427	$ 9,427	$ 9,427	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 188,530	$		$ 9,427	$ 9,427	$ 9,427	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - Care Centers Building, LLC	2002	16,845	432	35	432		5,309	3
4									4
5	Allocated - Extended Care Clinical. LLC	2002	3,172	81	35	81		1,000	5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Extended Care Consulting	2007	176	9	20	9		70	9
10	Allocated - Extended Care Consulting	2009	105	5	20	5		32	10
11	Allocated - Extended Care Consulting	2010	1,033	52	20	52		258	11
12	Allocated - Extended Care Consulting	2011	372	19	20	19		74	12
13	Allocated - Extended Care Consulting	2012	123	6	20	6		18	13
14	Allocated - Extended Care Consulting	2014	1,699	85	20	85		85	14
15									15
16	Allocated - Care Centers Building, LLC	2002	13,916	1,186	20	1,186		13,916	16
17	Allocated - Care Centers Building, LLC	2003	16,399	1,398	20	1,398		16,399	17
18	Allocated - Care Centers Building, LLC	2005	815	87	20	87		727	18
19	Allocated - Care Centers Building, LLC	2009	147	7	20	7		44	19
20	Allocated - Care Centers Building, LLC	2014	2,348	117	20	117		117	20
21									21
22	Allocated - Extended Care Clinical. LLC	2002	2,620	223	20	223		2,620	22
23	Allocated - Extended Care Clinical. LLC	2003	3,088	263	20	263		3,088	23
24	Allocated - Extended Care Clinical. LLC	2005	153	16	20	16		137	24
25	Allocated - Extended Care Clinical. LLC	2009	28	1	20	1		8	25
26	Allocated - Extended Care Clinical. LLC	2014	442	22	20	22		22	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 63,481	$ 4,009		$ 4,009	$	$ 43,924	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 63,481	$ 4,009		$ 4,009	$	$ 43,924	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 63,481	$ 4,009		$ 4,009	$	$ 43,924	34

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 180,393	$ 472	$ 27,344	$ 26,872	10	$ 99,263	71
72	Current Year Purchases	145,567	283	6,634	6,351	10	6,634	72
73	Fully Depreciated Assets	1,537,969				10	1,537,969	73
74								74
75	TOTALS	$ 1,863,930	$ 755	$ 33,978	$ 33,223		$ 1,643,867	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc - Ext. Care Consulting	2011	$ 6,912	$ 195	$ 195	$	5	$ 6,131	76
77		Alloc - Ext. Care Clinical	2012	3,247	649	649		5	1,609	77
78										78
79										79
80	TOTALS			$ 10,159	$ 844	$ 844	$		$ 7,740	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)	$ 9,848,477	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,887	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 256,730	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30,157)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,580,135	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	4 Door Frames	$ 14,875	92
93			93
94			94
95		$ 14,875	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.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 4,609 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	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.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 728,187	$		$ 728,187	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			136,890			136,890	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			697,740			697,740	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 prescrpts				683,925		683,925	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					19,824	157,002		176,826	13
14	TOTAL			$		$ 1,582,641	$ 840,927		$ 2,423,568	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.

STATE OF ILLINOIS

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,865	$ 40,828	1
2	Cash-Patient Deposits	17,642	17,642	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,352,480	1,352,480	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	284,368	284,368	6
7	Other Prepaid Expenses	6,248	6,248	7
8	Accounts Receivable (owners or related parties)	236,481	(331,791)	8
9	Other(specify):	2,726,808	2,948,437	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,626,892	$ 4,318,212	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		6,350,541	14
15	Leasehold Improvements, at Historical Cost	850,741	950,741	15
16	Equipment, at Historical Cost	659,225	1,859,225	16
17	Accumulated Depreciation (book methods)	(912,907)	(3,654,711)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 597,059	$ 5,955,796	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,223,951	$ 10,274,008	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,997,366	$ 2,997,365	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,349	19,349	28
29	Short-Term Notes Payable	107,418	107,418	29
30	Accrued Salaries Payable	178,242	178,242	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,645	19,645	31
32	Accrued Real Estate Taxes(Sch.IX-B)	585,032	585,032	32
33	Accrued Interest Payable		13,837	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			2,754,928	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,907,052	$ 6,675,816	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,120,110	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,120,110	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,907,052	$ 9,795,926	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,316,899	$ 478,082	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,223,951	$ 10,274,008	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 228,714	1	
2	Restatements (describe):		2	
3	**Prior year bad debt adjustment**	(184,101)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 44,613	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,272,286	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)**	$ 1,272,286	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)**	$ 1,316,899	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,490,312	1
2	Discounts and Allowances for all Levels	(6,947,835)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,542,477	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,235,890	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,235,890	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	2,643	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	693,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,709	19
20	Radiology and X-Ray	16,479	20
21	Other Medical Services	16,979	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 767,837	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73,756	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,756	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	55,780	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 55,780	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,675,740	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,739,871	31
32	Health Care	4,319,142	32
33	General Administration	2,491,531	33
	B. Capital Expense		
34	Ownership	1,130,364	34
	C. Ancillary Expense		
35	Special Cost Centers	2,423,568	35
36	Provider Participation Fee	298,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,403,454	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,272,286	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,272,286	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,171,088	44
45	Private Pay - Net Inpatient Revenue	786,890	45
46	Medicare - Net Inpatient Revenue	(10,794)	46
47	Other-(specify) Hospice	588,750	47
48	Other-(specify) Insurance	6,543	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,542,477	49

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

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

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

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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,937	2,286	$ 118,603	$ 51.88	1
2	Assistant Director of Nursing	1,621	1,862	71,342	38.31	2
3	Registered Nurses	19,924	22,159	721,915	32.58	3
4	Licensed Practical Nurses	41,617	44,943	1,195,329	26.60	4
5	CNAs & Orderlies	89,143	99,507	1,013,044	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,483	16,832	274,418	16.30	8
9	Activity Director	1,986	2,233	30,082	13.47	9
10	Activity Assistants	13,554	15,298	147,935	9.67	10
11	Social Service Workers	9,179	10,192	254,095	24.93	11
12	Dietician	1,673	1,948	27,380	14.06	12
13	Food Service Supervisor	1,867	2,073	50,047	24.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,807	6,308	72,838	11.55	15
16	Dishwashers	14,505	17,232	158,565	9.20	16
17	Maintenance Workers	5,785	6,424	122,954	19.14	17
18	Housekeepers	22,408	25,277	257,704	10.20	18
19	Laundry	8,285	9,462	86,633	9.16	19
20	Administrator	1,736	2,054	107,268	52.22	20
21	Assistant Administrator	1,786	2,004	55,124	27.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,512	8,573	176,672	20.61	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	3,116	3,577	58,395	16.33	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,991	2,205	37,818	17.15	33
34	TOTAL (lines 1 - 33)	269,915	302,449	$ 5,038,161 *	$ 16.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	314	$ 15,458	01-03	35
36	Medical Director	Monthly	38,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,069	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	$ 62,527		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Stucker	Administrator	0	$ 107,268
Sarah Simons	Asst. Administrator	0	55,124
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,392

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ext. Care Consulting	Home Office Allocation	$ 388,176
Ext. Care Clinical	Home Office Allocation	129,396
Personnel Planners	Unemployment Tax Cons.	3,325
Frost, Ruttenberg & Rothblatt	Accounting	25,700
Navex Global	Ethics and Compliance	237
Pinnacle Quality Insight	Customer Satisfaction	2,322
Prospect Resources	Natural Gas Procurement	1,300
DIAWA - HFG	Line of Credit	18,054
Legat Architechts	Architecture Consultant	2,879
Blymas	Tax Consultants	10,843
Plante & Moran	Accounting	703
See Supplemental Schedule		57,323
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 640,257

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 230,683
Unemployment Compensation Insurance	49,994
FICA Taxes	381,006
Employee Health Insurance	246,343
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	9,135
Pension Expense	32,508
Other Employee Welfare	12,748
Holiday Expense	2,431
TOTAL (agree to Schedule V, line 22, col.8)	$ 964,848

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	4,591
Health Care Worker Background Check	6,109
(Indicate # of checks performed 406)	
Patient Background Checks	
Licenses and Permits	6,368
Dues and Subscriptions	16,761
Allocated - Ext. Care Consulting	1,709
Allocated - Ext Care Clinical	255
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,785

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,890
Allocated - Ext. Care Consulting	268
Allocated - Ext. Care Clinical	1,337
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,495

**See instructions.

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Manor Nrsg & Reh Ctr # 0046011 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $12,580**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **80,353** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **298,978**
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. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
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.