

		FOR BHF USE					

LL1

**2015**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2015)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0050823</u></p> <p><b>Facility Name:</b> <u>Prairie City Rehab &amp; HC</u></p> <p><b>Address:</b> <u>825 E Main RR2 Bx97</u> <u>Prairie City</u> <u>61470</u>          Number City Zip Code</p> <p><b>County:</b> <u>McDonough</u></p> <p><b>Telephone Number:</b> <u>(309)775-3313</u> <b>Fax #</b> <u>(309)775-3311</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/9/2008</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2015</u> to <u>12/31/2015</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (_____) _____</td> <td>Fax # (_____) _____</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (_____) _____	Fax # (_____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Firm Name & Address) _____																																									
	(Telephone) (_____) _____	Fax # (_____) _____																																								
	<p>In the event there are further questions about this report, please contact:          Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u>          Email Address: _____</p>	<p> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630       </p>																																								

Facility Name & ID Number Prairie City Rehab & HC

# 0050823 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,155	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	47	TOTALS	47	17,155	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,425	2,811	441	8,677	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,425	2,811	441	8,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.58%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 9/9/2008

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 9/9/2008 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 47 and days of care provided 393

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	95,666	2,890		98,556		98,556	1,682	100,238		1
2	Food Purchase		60,212		60,212		60,212	(6,749)	53,463		2
3	Housekeeping	55,480	7,834		63,314		63,314	13	63,327		3
4	Laundry		2,262		2,262		2,262		2,262		4
5	Heat and Other Utilities			28,259	28,259		28,259	97	28,356		5
6	Maintenance	27,377	6,004	14,624	48,005		48,005	667	48,672		6
7	Other (specify):* Home Office Ben. Allocation										7
8	<b>TOTAL General Services</b>	178,523	79,202	42,883	300,608		300,608	(4,290)	296,318		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	374,611	23,585	2,302	400,498		400,498	(693)	399,805		10
10a	Therapy		109	66,208	66,317		66,317		66,317		10a
11	Activities	8,639	75		8,714		8,714	(8,639)	75		11
12	Social Services	27,041			27,041		27,041	(1,481)	25,560		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	<b>TOTAL Health Care and Programs</b>	410,291	23,769	74,510	508,570		508,570	(10,813)	497,757		16
	<b>C. General Administration</b>										
17	Administrative			96,900	96,900		96,900	(43,333)	53,567		17
18	Directors Fees										18
19	Professional Services			6,820	6,820		6,820	6,522	13,342		19
20	Dues, Fees, Subscriptions & Promotions			1,621	1,621		1,621	220	1,841		20
21	Clerical & General Office Expenses	10,554	2,434	4,853	17,841		17,841	19,696	37,537		21
22	Employee Benefits & Payroll Taxes			89,383	89,383		89,383	12,608	101,991		22
23	Inservice Training & Education							130	130		23
24	Travel and Seminar							29	29		24
25	Other Admin. Staff Transportation			5,460	5,460		5,460	1,323	6,783		25
26	Insurance-Prop.Liab.Malpractice			15,333	15,333		15,333	203	15,536		26
27	Other (specify):* Home Office Ben. Allocation										27
28	<b>TOTAL General Administration</b>	10,554	2,434	220,370	233,358		233,358	(2,602)	230,756		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	599,368	105,405	337,763	1,042,536		1,042,536	(17,705)	1,024,831		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 &amp; ID Number

Prairie City Rehab &amp; HC

#0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			41,625	41,625	41,625	4,527	46,152				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,919	6,919	6,919	33	6,952				32
33	Real Estate Taxes			4,829	4,829	4,829	220	5,049				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,379	11,379	11,379	255	11,634				35
36	Other (specify):* Home Office Ben. Allocation											36
37	<b>TOTAL Ownership</b>			64,752	64,752	64,752	5,035	69,787				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,876		5,876	5,876		5,876				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,703	75,703	75,703		75,703				42
43	Other (specify):* Home Office Ben. Allocati		61	17,729	17,790	17,790	(17,790)					43
44	<b>TOTAL Special Cost Centers</b>		5,937	93,432	99,369	99,369	(17,790)	81,579				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	599,368	111,342	495,947	1,206,657	1,206,657	(30,460)	1,176,197				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 City Rehab & HC

# 0050823

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,997)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,762)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	357	30		9
10	Interest and Other Investment Income	(64)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(211)	43		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	(9,294)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(908)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(14,391)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (34,270)		\$	30

<b>BHF USE ONLY</b>						
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	3,810	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 3,810		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (30,460)		37

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

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

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

Prairie City Rehab & HC

ID# 0050823

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (779)	43	1
2	X-Rays-Part A	(194)	43	2
3	Offset Miscellaneous Office Supplies Revenue	843	21	3
4	Disallowed Special Events	358	43	4
5	Offset Transportation Revenue	(8,639)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(744)	10	6
7	Offset Meals on Wheels	(3,755)	2	7
8	Offset Transportation Revenue	(1,481)	12	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(14,391)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1 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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	85	85	12
13	V							13
14	Total		\$			\$ 85	\$ *	85 14

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



**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 23	\$	23	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	0			16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0			17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0			18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	0			19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0			20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0			21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0			22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	329		329	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	0			24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0			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	<b>Total</b>		\$			\$ 352	\$ *	352	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	3,463	3,463	25	
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	144	144	26	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	821	821	34	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38	
39	<b>Total</b>		\$			\$ 4,428	\$ *	4,428	39

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

Facility Name &amp; ID Number

Prairie City Rehab &amp; HC

# 0050823

Report Period Beginning:

1/1/2015

Ending: 12/31/2015

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 1,682	\$ 1,682
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	3	3
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	13	13
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	97	97
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	667	667
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	51	51
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	96,900	Petersen Health Care Management, Inc.	100.00%	53,567	(43,333)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	2,974	2,974
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	53	53
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	18,853	18,853
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	12,608	12,608
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	130	130
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	29	29
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,323	1,323
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	203	203
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	3,020	3,020
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	97	97
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	220	220
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	255	255
39	Total		\$ 96,900			\$ 95,845	\$ * (1,055)

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

Facility Name &amp; ID Number

Prairie City Rehab &amp; HC

# 0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## 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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name &amp; ID Number

Prairie City Rehab &amp; HC

# 0050823

Report Period Beginning:

1/1/2015

Ending:

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## 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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name &amp; ID Number

Prairie City Rehab &amp; HC

# 0050823

Report Period Beginning:

1/1/2015

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12/31/2015

## 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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

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Report Period Beginning:

1/1/2015

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12/31/2015

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				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 &amp; ID Number

Prairie City Rehab &amp; HC

#

0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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



Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 0	\$ 0	8,677	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	8,677	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	8,677	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	8,677	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	8,677	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	8,677	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	8,677	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	8,677	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	8,677	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	8,677	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	8,677	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	8,677	85	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	8,677	23	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	8,677	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	8,677	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	8,677	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	8,677	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	8,677	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	8,677	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	8,677	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	8,677	329	21
22	32	Interest	Resident Days	1,553,881	75	0	0	8,677	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	8,677	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	8,677	0	24
25	TOTALS					\$ 78,110	\$		\$ 437	25

Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 Midwest Health Operations, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309)691-8113  
 Fax Number (309)691-8622

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	160,585	10		8,677		1
2	2	Food	Resident Days	160,585	10		8,677		2
3	3	Housekeeping	Resident Days	160,585	10		8,677		3
4	4	Laundry	Resident Days	160,585	10		8,677		4
5	5	Utilities	Resident Days	160,585	10		8,677		5
6	6	Maintenance	Resident Days	160,585	10		8,677		6
7	7	Mgmt. Allocation of Benefits	Resident Days	160,585	10		8,677		7
8	10	Nursing and Medical Records	Resident Days	160,585	10		8,677		8
9	15	Mgmt. Allocation of Benefits	Resident Days	160,585	10		8,677		9
10	17	Administrative	Resident Days	160,585	10		8,677		10
11	19	Professional Services	Resident Days	160,585	10	64,091	8,677	3,463	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	160,585	10	2,658	8,677	144	12
13	21	Clerical and General Office	Resident Days	160,585	10		8,677		13
14	22	Employee Benefits & Payroll	Resident Days	160,585	10		8,677		14
15	23	Inservice Training & Education	Resident Days	160,585	10		8,677		15
16	24	Travel and Seminar	Resident Days	160,585	10		8,677		16
17	25	Other Admin. Staff Transport.	Resident Days	160,585	10		8,677		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	160,585	10		8,677		18
19	27	Mgmt. Allocation of Benefits	Resident Days	160,585	10		8,677		19
20	30	Depreciation	Resident Days	160,585	10	15,190	8,677	821	20
21	32	Interest	Resident Days	160,585	10		8,677		21
22	33	Real Estate Taxes	Resident Days	160,585	10		8,677		22
23	34	Rent-Facility and Grounds	Resident Days	160,585	10		8,677		23
24	35	Rent-Equipment & Vehicles	Resident Days	160,585	10		8,677		24
25	TOTALS					\$ 81,939	\$	\$ 4,428	25

Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

Name of Related Organization Petersen Health Care Management, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 301,135	\$ 292,840	8,677	\$ 1,682	1
2	2	Food	Resident Days	1,553,881	75	480	8,677	3		2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	8,677	13	3
4	5	Utilities	Resident Days	1,553,881	75	17,327	8,677	97		4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	8,677	667	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75		8,677			6
7	9	Medical Director	Resident Days	1,553,881	75		8,677			7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192	8,677	51		8
9	10A	Therapy	Resident Days	1,553,881	75		8,677			9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75		8,677			10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	8,677	53,567	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666	8,677	2,974		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548	8,677	53		13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	8,677	18,853	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824	8,677	12,608		15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223	8,677	130		16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279	8,677	29		17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965	8,677	1,323		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398	8,677	203		19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75		8,677			20
21	30	Depreciation	Resident Days	1,553,881	75	540,826	8,677	3,020		21
22	32	Interest	Resident Days	1,553,881	75	17,439	8,677	97		22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471	8,677	220		23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727	8,677	255		24
25	TOTALS					\$ 12,370,446	\$ 8,182,044	\$ 95,845		25

Facility Name & ID Number

Prairie City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Ipava Bank		X	Mortgage	\$2,677.97	4/21/06	\$ 320,000	\$ Retired			\$ 6,919	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$2,677.97		\$ 320,000	\$			\$ 6,919	9					
<b>B. Non-Facility Related*</b>																	
10											97	10					
11											(64)	11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 33	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 320,000	\$			\$ 6,952	15					

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>4,728</b>		<b>1</b>
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.)		\$	<b>4,709</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(19)</b>		<b>3</b>
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>4,848</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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.					
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>Home Office Allocation</b> <b>220</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>5,049</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>4,616</u>	<u>8</u>	<b>FOR BHF USE ONLY</b>	
	2011	<u>4,587</u>	<u>9</u>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$ <b>13</b>
	2012	<u>4,766</u>	<u>10</u>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2013	<u>4,591</u>	<u>11</u>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2014	<u>4,709</u>	<u>12</u>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>Accrual based on prior year tax bill.</b>					

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Rehab & HC COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0050823

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

TELEPHONE (309)691-8113 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-000-022-05</u>	<u>Long-Term Care Facility</u>	\$ <u>4,708.76</u>	\$ <u>4,708.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>4,708.76</u></u>	\$ <u><u>4,708.76</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.

Facility Name & ID Number Prairie City Rehab & HC

# 0050823 Report Period Beginning:

1/1/2015 Ending:

12/31/2015

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 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	<u>Facility</u>	<u>216,058</u>	<u>2008</u>	<u>\$ 120,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>216,058</b>		<b>\$ 120,000</b>	<b>3</b>



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	47	2008	1970	\$ 562,500	\$	25	\$ 22,500	\$ 22,500	\$ 168,750
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	Fire Alarm Control	2008		2,608		15	174	174	1,131
10	Patch Parking Lot	2009		3,200		7	458	458	2,519
11	Boiler Repair	2010		2,989		7	428	428	1,926
12	Roof Replacement on Low-Sloped Roof	2011		51,550		25	2,062	2,062	9,279
13	Sprinkler System Replacement	2012		103,900		25	4,156	4,156	18,702
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				581			(581)	
28	Building Booked				22,500			(22,500)	
29	Building Improvement Booked				6,819			(6,819)	
30									
31	2015-Home Office Allocation-Building Improvements			3,797			91	91	
32	2015-Home Office Allocation-Land Improvements			354			23	23	
33									
34									
35									
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 City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 730,898	\$ 29,900		\$ 29,892	\$ (8)	\$ 202,307	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 123,705	\$ 11,725	\$ 12,204	\$ 479	5-10 yrs.	\$ 100,403	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,056	4,056			74
75	TOTALS	\$ 123,705	\$ 11,725	\$ 16,260	\$ 4,535		\$ 100,403	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 974,603	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,625	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,152	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,527	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 302,710	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 11,634 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				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.

**Prairie City Rehab & HC**

**0050823**

**Period Beginning 1/1/2015**

**Period End 12/31/2015**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 7,316
Dishwasher	1,051
Maintenance Equip.	40
Copier	2,972
Home Office Allocation	255
	<u>11,634</u>

Facility Name & ID Number Prairie City Rehab & HC # 0050823 Report Period Beginning: 1/1/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,023	\$ 30,347	\$	2,023	\$ 30,347	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		218	3,263		218	3,263	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,173	32,598	109	2,173	32,707	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				5,876		5,876	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	4,414	\$ 66,208	\$ 5,985	4,414	\$ 72,193	14	

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

Facility Name & ID Number Prairie City Rehab & HC # 0050823 Report Period Beginning: 1/1/2015 Ending: 12/31/2015  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (687,959)	\$ (687,959)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>68,397</u> )	133,255	133,255	3
4	Supply Inventory (priced at <u>Cost</u> )	4,990	4,990	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,446	15,446	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (534,268)	\$ (534,268)	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	120,000	120,000	13
14	Buildings, at Historical Cost	562,500	566,297	14
15	Leasehold Improvements, at Historical Cost	166,822	164,601	15
16	Equipment, at Historical Cost	123,705	123,705	16
17	Accumulated Depreciation (book methods)	(315,214)	(302,710)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 657,813	\$ 671,893	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 123,545	\$ 137,625	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 222,180	\$ 222,180	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,296	33,296	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,978	39,978	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,848	4,848	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	51,729	51,729	36
37	<u>Accrued Management Fees</u>	493,886	493,886	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 845,917	\$ 845,917	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 845,917	\$ 845,917	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (722,372)	\$ (708,292)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 123,545	\$ 137,625	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(650,447)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustments Made After Cost Report Was Filed</b>	<b>800</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(649,647)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(72,725)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(72,725)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(722,372)</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,067,683	1
2	Discounts and Allowances for all Levels	(41,506)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,026,177</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	80,117	6
7	Oxygen	8	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 80,125</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,752	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	748	20
21	Other Medical Services	696	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 17,545</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	64	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 64</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	10,120	28
28a	<u>Miscellaneous Revenue</u>	(99)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,021</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,133,932</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	300,608	31
32	Health Care	508,570	32
33	General Administration	233,358	33
<b>B. Capital Expense</b>			
34	Ownership	64,752	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	23,666	35
36	Provider Participation Fee	75,703	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,206,657</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(72,725)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (72,725)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 595,007	44
45	Private Pay - Net Inpatient Revenue	332,876	45
46	Medicare - Net Inpatient Revenue	91,174	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	8,410	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(1,290)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,026,177</b>	49

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

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

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

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

Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,007	2,047	\$ 52,326	\$ 25.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,678	3,678	76,411	20.78	3
4	Licensed Practical Nurses	4,995	5,019	88,391	17.61	4
5	CNAs & Orderlies	14,893	15,290	157,483	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	27,041	13.00	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,813	13.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,338	7,531	66,853	8.88	15
16	Dishwashers					16
17	Maintenance Workers	1,640	1,846	27,377	14.83	17
18	Housekeepers	6,293	6,293	55,480	8.82	18
19	Laundry					19
20	Administrator	2,025	2,025	53,567	26.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,052	1,052	10,554	10.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	788	788	8,639	10.96	33
34	TOTAL (lines 1 - 33)	48,869	49,729	\$ 652,935 *	\$ 13.13	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 6,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,835	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,835		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description	Amount	Description	Amount		
Carmela Morris	Administrator	0	\$ 34,125	Workers' Compensation Insurance	\$ 23,885	IDPH License Fee	\$		
Shayli Hines	Administrator	0	19,442	Unemployment Compensation Insurance	24,620	Advertising: Employee Recruitment		80	
				FICA Taxes	45,155	Health Care Worker Background Check			
				Employee Health Insurance	(4,667)	(Indicate # of checks performed <u>71</u> )		1,016	
				Employee Meals		<u>Miscellaneous Licenses &amp; Permits</u>		525	
				Illinois Municipal Retirement Fund (IMRF)*		<u>Miscellaneous Dues &amp; Subscriptions</u>			
				Employee Relations	390	<u>Home Office Allocation</u>		220	
				Home Office Allocation	12,608				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,567						
B. Administrative - Other			Amount	TOTAL (agree to Schedule V, line 22, col.8)			Less: Public Relations Expense ( )		
Description			Amount			Non-allowable advertising ( )		TOTAL (agree to Sch. V, line 20, col. 8)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 96,900	\$ 101,991		Yellow page advertising ( )		\$ 1,841	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 96,900	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount		
E-Health Data Solutions	Computer Services	\$ 4,421				Out-of-State Travel	\$		
Mediacom	Computer Services	1,631							
Honkamp Kruger	Accounting Services	768				In-State Travel			
			N/A						
						Seminar Expense			
						Home Office Allocation		29	
						Entertainment Expense ( )			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,820	TOTAL		TOTAL (agree to Sch. V, line 24, col. 8)		\$ 29	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Prairie City Rehab & HC**

**0050823**

**Period Beginning**

**1/1/2015**

**Period End**

**12/31/2015**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		6,820

**Home Office Allocation**

Denton's US LLP	Legal	42
Applegate and Thorne	Legal	7
Miller Hall and Triggs	Legal	6
Healthcare Resources International	Legal	35
Lexis Nexis	Legal	2
GoffWilson	Legal	289
CliftonLarson Allen	Accountants	452
Ginoli & Co.	Accountants	1,086
Miscellaneous	Computer Services	22
CCH	Computer Services	5
PTC Select	Computer Services	7
Advanced Answers on Demand	Computer Services	926
Stratus Networks	Computer Services	168
Kemper Technology	Computer Services	248
AT&T	Computer Services	2
Ability Network	Computer Services	238
CIAN	Computer Services	168
Comcast	Computer Services	6
Emdeon	Computer Services	14
Charter Communications	Computer Services	11
Allscripts	Computer Services	8
Allpayer Exchange	Computer Services	5
E-Health Technologies	Computer Services	4
Macquarie Technology Services	Computer Services	6
Optimizer	Other Prof Fees	16

D.J. Howard Appraisers	Other Prof Fees	15
Key Corporate Services	Other Prof Fees	49
Consolidated Land Surveying	Other Prof Fees	31
Alan Litwiller	Other Prof Fees	6
Marotta Gund Budd Derza	Other Prof Fees	2648

Total (agree to Schedule V, line 19, column 8)	<u>13,342</u>
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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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Prairie City Rehab & HC

# 0050823

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,998 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 75,703  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,997
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 10,120
  - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - 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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.