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.

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

I. IDPH License ID Number: 0046011

Facility Name: Prairie Manor Nursing & Rehab Center

Address: 345 Dixie Hwy (Number) Chicago Heights (City) 60491 (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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	29,644	3,273	12,909	45,826	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,644	3,273	12,909	45,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.83%

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 11,537

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: 12/31/15 Fiscal Year: 12/31/15

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

STATE OF ILLINOIS

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	317,984	66,326	17,127	401,437		401,437	8,553	409,990			1
2	Food Purchase		290,706		290,706		290,706	200	290,906			2
3	Housekeeping	256,916	63,010		319,926		319,926	1,179	321,105			3
4	Laundry	77,721	29,669		107,390		107,390		107,390			4
5	Heat and Other Utilities			196,396	196,396		196,396	1,772	198,168			5
6	Maintenance	119,775		276,009	395,784		395,784	11,264	407,048			6
7	Other (specify):*							4,310	4,310			7
8	**TOTAL General Services**	772,396	449,711	489,532	1,711,639		1,711,639	27,278	1,738,917			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	3,275,263	299,772	130,845	3,705,880		3,705,880	40,952	3,746,832			10
10a	Therapy	264,354		372	264,726		264,726		264,726			10a
11	Activities	200,770	34,849		235,619		235,619		235,619			11
12	Social Services	218,176			218,176		218,176	23,969	242,145			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,220	8,220			15
16	**TOTAL Health Care and Programs**	3,958,563	334,621	155,717	4,448,901		4,448,901	73,141	4,522,042			16
	C. General Administration											
17	Administrative	166,281			166,281		166,281	84,210	250,491			17
18	Directors Fees											18
19	Professional Services			701,914	701,914	(26,946)	674,968	(533,183)	141,785			19
20	Dues, Fees, Subscriptions & Promotions			82,309	82,309		82,309	(38,767)	43,542			20
21	Clerical & General Office Expenses	209,235	61,980	228,192	499,407		499,407	(42,316)	457,091			21
22	Employee Benefits & Payroll Taxes			927,139	927,139		927,139	(5,828)	921,311			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,558	2,558		2,558	1,400	3,958			24
25	Other Admin. Staff Transportation			1,236	1,236		1,236	1,302	2,538			25
26	Insurance-Prop.Liab.Malpractice			211,411	211,411		211,411	1,848	213,259			26
27	Other (specify):*							30,082	30,082			27
28	**TOTAL General Administration**	375,516	61,980	2,154,759	2,592,255	(26,946)	2,565,309	(501,252)	2,064,056			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,106,475	846,312	2,800,008	8,752,795	(26,946)	8,725,849	(400,833)	8,325,016			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 Nursing & Rehab Center #0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			118,836	118,836		118,836	159,248	278,084			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							196,343	196,343			32
33	Real Estate Taxes			679,286	679,286	26,946	706,232	4,682	710,914			33
34	Rent-Facility & Grounds			457,000	457,000		457,000	(457,000)				34
35	Rent-Equipment & Vehicles			2,724	2,724		2,724	777	3,501			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,257,846	1,257,846	26,946	1,284,792	(95,950)	1,188,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		654,044	1,541,258	2,195,302		2,195,302	(3,271)	2,192,031			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			289,651	289,651		289,651		289,651			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		654,044	1,830,909	2,484,953		2,484,953	(3,271)	2,481,682			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,106,475	1,500,356	5,888,763	12,495,594		12,495,594	(500,054)	11,995,540			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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(78,611)	30		9
10	Interest and Other Investment Income	(62,040)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(204)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions	(822)	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	(157,819)	21		24
25	Fund Raising, Advertising and Promotional	(31,262)	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	(55,724)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (387,912)		$	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)	(112,142)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (112,142)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (500,054)		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 Nursing & Rehab Center

ID# 0046011

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (5,043)	21	1
2	Jury Duty	(34)	10	2
3	Theft Loss	(561)	21	3
4	Collection Expense	(6,865)	21	4
5	Capitalized R&M	(2,761)	06	5
6	Pac Dues	(7,556)	20	6
7	Annual Report	(250)	20	7
8	Non-Allowable Legal	(21,328)	19	8
9	Building Company - Management Fees	(7,300)	21	9
10	Building Company - Filing Fee	(250)	21	10
11	Building Company - Amortization Expense	(3,775)	31	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,724)		49

Prairie Manor Nursing & Rehab Center

ID# 0046011

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			152		8,401							8,553	1
2	Food Purchase	(204)		404									200	2
3	Housekeeping			1,065		114							1,179	3
4	Laundry													4
5	Heat and Other Utilities			1,614		158							1,772	5
6	Maintenance	(2,761)		4,645	9,262	118							11,264	6
7	Other (specify):*				3,249	1,061							4,310	7
8	**TOTAL General Services**	(2,965)		7,880	12,511	9,852							27,278	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)				41,083			(96)				40,952	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,969							23,969	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,220							8,220	15
16	**TOTAL Health Care and Programs**	(34)				73,272			(96)				73,141	16
	C. General Administration													
17	Administrative			2,903	16,242	65,065							84,210	17
18	Directors Fees													18
19	Professional Services	(21,328)		(383,046)		(128,809)							(533,183)	19
20	Fees, Subscriptions & Promotions	(39,890)		952		171							(38,767)	20
21	Clerical & General Office Expenses	(179,268)	7,550	11,883	97,276	20,243							(42,316)	21
22	Employee Benefits & Payroll Taxes				(5,828)								(5,828)	22
23	Inservice Training & Education													23
24	Travel and Seminar			327		1,073							1,400	24
25	Other Admin. Staff Transportation			1,302									1,302	25
26	Insurance-Prop.Liab.Malpractice			1,328		520							1,848	26
27	Other (specify):*				19,487	10,595							30,082	27
28	**TOTAL General Administration**	(240,486)	7,550	(364,351)	127,177	(31,142)							(501,252)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(243,486)	7,550	(356,471)	139,688	51,982			(96)				(400,833)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center** **# 0046011** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(78,611)	235,056	2,105		698							159,248	30
31	Amortization of Pre-Op. & Org.	(3,775)	3,775											31
32	Interest	(62,040)	249,718	8,466		199							196,343	32
33	Real Estate Taxes			4,243		439							4,682	33
34	Rent-Facility & Grounds		(457,000)										(457,000)	34
35	Rent-Equipment & Vehicles			777									777	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(144,426)	31,549	15,591		1,336							(95,950)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(3,271)				(3,271)	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**								(3,271)				(3,271)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(387,912)	39,099	(340,880)	139,688	53,318			(3,367)				(500,054)	45

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 457,000	Prairie Manor Property, LLC	100.00%	$	$ (457,000)	1
2	V	32	Interest Income	222	Prairie Manor Property, LLC	100.00%		(222)	2
3	V	21	Management Fees		Prairie Manor Property, LLC	100.00%	7,300	7,300	3
4	V	21	Filing Fee		Prairie Manor Property, LLC	100.00%	250	250	4
5	V	30	Depreciation Expense		Prairie Manor Property, LLC	100.00%	235,056	235,056	5
6	V	31	Amortization Expense		Prairie Manor Property, LLC	100.00%	3,775	3,775	6
7	V	32	Interest Expense - Providence		Prairie Manor Property, LLC	100.00%	249,940	249,940	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 457,222			$ 496,321	$ * 39,099	14

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 152	$ 152	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	404	404	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,065	1,065	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,614	1,614	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,645	4,645	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,903	2,903	20
21	V	19	Professional Fees	388,176	Extended Care Consulting, LLC	100.00%	5,130	(383,046)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	952	952	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,883	11,883	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	327	327	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,302	1,302	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,328	1,328	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,105	2,105	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,466	8,466	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,243	4,243	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	777	777	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			$ 47,296	$ * (340,880)	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	9,262	$ 9,262	15
16	V	06	Maintenance (Direct)	19,428	Extended Care Consulting, LLC	100.00%	19,428		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	797	797	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,452	2,452	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,242	16,242	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	97,276	97,276	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,487	19,487	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	5,828	Extended Care Consulting, LLC	100.00%		(5,828)	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			$ 25,256			$ 164,944	$ * 139,688	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 114	$ 114	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	158	158	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	118	118	17
18	V	19	Professional Fees	129,396	Extended Care Clinical, LLC	100.00%	587	(128,809)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	171	171	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,454	1,454	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,073	1,073	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	520	520	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	698	698	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	199	199	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	439	439	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,401	8,401	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,061	1,061	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	41,083	41,083	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	23,969	23,969	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,220	8,220	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	65,065	65,065	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	18,789	18,789	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,595	10,595	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,396			$ 182,714	$ * 53,318	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	26,200	Vent Lease LLC	100.00%	26,200	$	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			$ 26,200			$ 26,200	$ *	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 165,463	$ 165,463	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	165,463	CCS Employee Benefits Group	100.00%		(165,463)	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			$ 165,463			$ 165,463	$ *	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 and Medical Records	$ 7,279	MAC Rx, LLC	100.00%	$ 7,183	$ (96)	15
16	V	39	Ancillary	247,695	MAC Rx, LLC	100.00%	244,424	(3,271)	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			$ 254,974			$ 251,607	$ * (3,367)	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	KATHRYN VALES ACCUM. TRUST	11.11 %	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	KIMBERLY RICHMAN ACCUM. TRUST	11.11 %	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING LLC	EVANSTON	BUILDING CO.	4
5	MELISSA ROTHNER ACCUM. TRUST	11.11 %	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6	NATHAN & SHIRLEY ROTHNER TRUST	22.22 %	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7	RACHEL ROTHNER ACCUM. TRUST	11.11 %	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8	WILLIAM ROTHNER ACCUM. TRUST	11.11 %	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	01	Dietary	Patient Days	1,326,152	31	$ 4,390	$	45,826	$ 152	1
2	02	Food	Patient Days	1,326,152	31	11,689		45,826	404	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		45,826	1,065	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		45,826	1,614	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		45,826	4,645	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		45,826	2,903	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		45,826	5,130	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		45,826	952	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		45,826	11,883	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		45,826	327	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		45,826	1,302	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		45,826	1,328	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		45,826	2,105	13
14	32	Interest	Patient Days	1,326,152	31	244,990		45,826	8,466	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		45,826	4,243	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		45,826	777	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 47,296	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	45,826	9,262	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		19,428	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		45,826	797	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			2,452	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	45,826	16,242	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	45,826	97,276	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		45,826	19,487	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253				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					$ 4,964,932	$ 4,280,758		$ 164,944	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	794,254	19	$ 1,974	$	45,826	$ 114	1
2	05	Utilities	Patient Days	794,254	19	2,745		45,826	158	2
3	06	Maintenance	Patient Days	794,254	19	2,053		45,826	118	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		45,826	587	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		45,826	171	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		45,826	1,454	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		45,826	1,073	7
8	26	Insurance	Patient Days	794,254	19	9,008		45,826	520	8
9	30	Depreciation	Patient Days	794,254	19	12,096		45,826	698	9
10	32	Interest	Patient Days	794,254	19	3,455		45,826	199	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		45,826	439	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	45,826	8,401	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		45,826	1,061	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	45,826	41,083	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	45,826	23,969	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		45,826	8,220	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	45,826	65,065	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	45,826	18,789	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		45,826	10,595	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 182,714	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						26,200	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					$	$		$ 26,200	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 165,463	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					$	$		$ 165,463	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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 And Medical Records	Direct Allocation			$	$		$ 7,183	1
2	39	Ancillary	Direct Allocation						244,424	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					$	$		$ 251,607	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$ 6,288,762			$ 249,940	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mattresses		X					40,964				6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,329,726			$ 249,940	9
	B. Non-Facility Related*											
10	Interest Income		X								(62,040)	10
11	Interest Income - Bldg. Co		X								(222)	11
12	Allocated - EC Consulting	X									8,466	12
13	See Supplemental Schedule										199	13
14	TOTAL Non-Facility Related						$	$			$ (53,597)	14
15	TOTALS (line 9+line14)						$	$ 6,329,726			$ 196,343	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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated - EC Clinical	X					$	$			$ 199	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										199	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 Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	585,019	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.)	$	621,416	2
3. Under or (over) accrual (line 2 minus line 1).	$	36,397	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	647,571	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.**	$	26,946	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** $ 31,938 **For** 2011 **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.	$	710,915	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	365,726	8
	2011	512,458	9
	2012	537,669	10
	2013	557,173	11
	2014	616,734	12

2015 Accrual = $616,734 x 1.05 =$647,571 (Rounding)
Allocated - Extended Care Consulting = $4,243
Allocated - Extended Care Clinical = $439
***Beginning Accrual Adjusted**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center 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 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) 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	$ 616,734.42	$ 616,734.42
2.	See Attached	Allocated from 2201 W. Main	$ 165,913.23	$ 4,441.21
3.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 131.82
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 786,462.31	$ 621,307.45

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 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.

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 Nursing & Rehab Center 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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 459,864	1
2	Allocated from 2201 W. Main, LLC / Clinical			21,950	2
3	TOTALS			$ 481,814	3

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 235,056	39	$ 119,231	$ (115,825)	$ 1,541,048	4
5				2013	1,609,158		39	41,260	41,260	123,780	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	33,716		20	1,524	1,524	21,926	9
10	Various			2004	215,253		20	9,744	9,744	139,319	10
11	Various			2005	96,470		20	2,221	2,221	75,568	11
12	Various			2006	90,263		20	4,360	4,360	44,805	12
13	Various			2007	56,209		20	2,810	2,810	24,828	13
14	Various			2008	31,219		20	1,871	1,871	14,157	14
15	Various			2009	43,314		20	1,608	1,608	21,577	15
16	Various			2010	44,836		20	2,242	2,242	11,725	16
17	Various			2011	104,287		20	5,947	5,947	26,346	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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)								67
68	Related Party Allocations (Pages 12H & 12I)		92,447	1,248		1,248		67,206	68
69	Financial Statement Depreciation			118,836			(118,836)		69
70	TOTAL (lines 4 thru 69)		$ 7,067,173	$ 355,140		$ 194,066	$ (161,074)	$ 2,112,286	70

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 7,067,173	$ 355,140		$ 194,066	$ (161,074)	$ 2,112,286	1
2	Replace Gypsum With Glass Boards	2012	29,840		20	1,492	1,492	5,968	2
3	Glass/Metal Store Front Construction	2012	20,465		20	1,023	1,023	3,922	3
4	Remove And Replace Concrete Slab In Dock Area	2012	10,500		20	525	525	1,663	4
5	Window Replacement	2012	2,850		20	143	143	558	5
6	Window Replacement	2012	2,850		20	143	143	546	6
7	Replace Concrete Slab - Handicap Ramp	2012	5,000		20	250	250	854	7
8	Boiler Modifications	2013	17,584		20	879	879	2,564	8
9	Sewer Repair	2013	2,555		20	128	128	373	9
10	Furnish & Install New Buffer Channel & Spring In Elevator	2013	37,400		20	1,870	1,870	4,831	10
11	Installed 2 New 200 Ampere Three Phase Three Wire 208 Volt Fee	2013	6,625		20	331	331	856	11
12	Installed Hot Water Coil & Pump Assembly	2014	15,382		20	769	769	1,538	12
13	Repair Heating System, Valve, Panel Guage, Thermostats, Transn	2014	4,215		20	211	211	404	13
14	Furnish & Install 4 Door Restrictors	2014	5,960		20	298	298	571	14
15	Replaced Cracked Coils On Air Unit	2014	41,310		20	2,066	2,066	3,959	15
16	Remove & Install 2 Mixing Valves	2014	4,439		20	222	222	425	16
17	Emergency Coil Repairs	2014	13,690		20	685	685	1,198	17
18	Furnish & Install 2 Faux Stucco Signs	2014	17,328		20	1,155	1,155	1,637	18
19	Replace Actuator For Outside Air Dampler For Air Handler	2014	9,149		20	457	457	496	19
20	Installed New Valves On Boiler	2014	3,933		20	197	197	361	20
21	Millwork, Patch Walls, Repair Floor, Updated Plumbing & Electr	2014	28,800		20	1,440	1,440	2,760	21
22	Excavated & Repaired Leak On Auxiliary Valve On Fire Hydrant	2014	3,250		20	163	163	257	22
23	Reception Area/Meeting Room - Ceilings, Wood Trim, Doors, Tile	2014	188,530		20	9,427	9,427	18,853	23
24	New Awnings	2015	6,100		20	559	559	559	24
25	Replaced 28Ft Of Pipes	2015	15,663		20	653	653	653	25
26	Generator Installation	2015	119,422		20	1,493	1,493	1,493	26
27	8 Wood Doors	2015	4,967		20	103	103	103	27
28	Walk-In Freezer Doors	2015	7,346		20	490	490	490	28
29	Flood Light And Fixtures	2015	4,600		20	96	96	96	29
30	Ice/Water Shield, Standing Seam Roof & Metal Gutters And Dowr	2015	15,653		20	783	783	783	30
31	4 Doors And Frames	2015	34,250		20	173	173	173	31
32	Installation Of Generator	2015	58,500		20	2,194	2,194	2,194	32
33	Replace Leaking Domestic Booster Pump On Hot Water Boiler	2015	2,761		20	138	138	138	33
34	TOTAL (lines 1 thru 33)		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	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)		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	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)		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	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)		$ 7,808,089	$ 355,140		$ 224,618	$ (130,522)	$ 2,173,560	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	27,327	701	39	701		9,313	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	2,921	75	39	75		996	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	159	8	20	8		72	9
10	Allocated from Extended Care Consulting, LLC	2009	95	5	20	5		33	10
11	Allocated from Extended Care Consulting, LLC	2010	932	47	20	47		280	11
12	Allocated from Extended Care Consulting, LLC	2011	336	17	20	17		84	12
13	Allocated from Extended Care Consulting, LLC	2012	111	6	20	6		22	13
14	Allocated from Extended Care Consulting, LLC	2014	1,533	77	20	77		153	14
15									15
16	Allocated from 2201 W. Main, LLC	2002	22,574		20			22,574	16
17	Allocated from 2201 W. Main, LLC	2003	26,603		20			26,603	17
18	Allocated from 2201 W. Main, LLC	2005	1,322	140	20	140		1,319	18
19	Allocated from 2201 W. Main, LLC	2009	239	12	20	12		83	19
20	Allocated from 2201 W. Main, LLC	2014	2,218	111	20	111		222	20
21	Allocated from 2201 W. Main, LLC	2015	376	19	20	19		19	21
22									22
23	Allocated from Extended Care Clinical, LLC	2002	2,413		20			2,413	23
24	Allocated from Extended Care Clinical, LLC	2003	2,844		20			2,844	24
25	Allocated from Extended Care Clinical, LLC	2005	141	15	20	15		141	25
26	Allocated from Extended Care Clinical, LLC	2009	26	1	20	1		9	26
27	Allocated from Extended Care Clinical, LLC	2014	237	12	20	12		24	27
28	Allocated from Extended Care Clinical, LLC	2015	40	2	20	2		2	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,447	$ 1,248		$ 1,248	$	$ 67,206	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 92,447	$ 1,248		$ 1,248	$	$ 67,206	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)		$ 92,447	$ 1,248		$ 1,248	$	$ 67,206	34

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 292,510	$ 681	$ 52,592	$ 51,911	10	$ 125,775	71
72	Current Year Purchases	1,065	107	107		10	107	72
73	Fully Depreciated Assets	1,562,900				10	1,562,900	73
74								74
75	TOTALS	$ 1,856,476	$ 788	$ 52,699	$ 51,911		$ 1,688,783	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		Allocated from EC Consulting, LL	2015	$ 6,236	$ 176	$ 176	$	5	$ 5,708	76
77		Allocated from EC Clinical, LLC	2012	2,964	593	593		5	2,062	77
78										78
79										79
80	TOTALS			$ 9,200	$ 769	$ 769	$		$ 7,770	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)	$ 10,155,578	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 356,697	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,086	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (78,611)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,870,113	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 3,501 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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 692,768	$		$ 692,768	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			113,114			113,114	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			709,176			709,176	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				542,765		542,765	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					26,200	111,279		137,479	13
14	TOTAL			$		$ 1,541,258	$ 654,044		$ 2,195,302	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 Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 4,620	$ 91,065	1
2	Cash-Patient Deposits	25,636	25,636	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,204,399	1,204,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	320,332	320,332	6
7	Other Prepaid Expenses	21,988	22,976	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,950,008	4,127,546	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,526,983	$ 5,791,954	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		459,864	13
14	Buildings, at Historical Cost		6,350,541	14
15	Leasehold Improvements, at Historical Cost	1,225,225	1,325,225	15
16	Equipment, at Historical Cost	527,203	1,727,203	16
17	Accumulated Depreciation (book methods)	(1,031,743)	(4,616,575)	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):		46,563	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 720,685	$ 5,292,821	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,247,668	$ 11,084,775	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,853,193	$ 2,853,193	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,534	19,534	28
29	Short-Term Notes Payable	40,964	40,964	29
30	Accrued Salaries Payable	203,514	203,514	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,747	5,747	31
32	Accrued Real Estate Taxes(Sch.IX-B)	647,571	647,571	32
33	Accrued Interest Payable		24,369	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	34,919	34,919	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,805,442	$ 3,829,811	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,288,762	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)**	$	$ 6,288,762	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,805,442	$ 10,118,573	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,442,226	$ 966,202	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,247,668	$ 11,084,775	48

***(See instructions.)**

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,316,899	1
2	Restatements (describe):		2
3	**Rounding**	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,316,894	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,125,332	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)**	$ 1,125,332	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,442,226	24 *

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 13,493,033	1
2	Discounts and Allowances for all Levels	(6,665,517)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,827,516	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,029,925	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,029,925	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	2,539	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	547,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,720	19
20	Radiology and X-Ray	17,359	20
21	Other Medical Services	56,781	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 665,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,040	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,040	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	35,784	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,784	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,620,926	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,711,639	31
32	Health Care	4,448,901	32
33	General Administration	2,592,255	33
	B. Capital Expense		
34	Ownership	1,257,846	34
	C. Ancillary Expense		
35	Special Cost Centers	2,195,302	35
36	Provider Participation Fee	289,651	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,495,594	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,125,332	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,125,332	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,000,355	44
45	Private Pay - Net Inpatient Revenue	640,339	45
46	Medicare - Net Inpatient Revenue	419,285	46
47	Other-(specify) Hospice	658,180	47
48	Other-(specify) Insurance	109,357	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,827,516	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.**

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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	1,954	2,215	$ 108,291	$ 48.89	1
2	Assistant Director of Nursing	1,759	2,021	74,195	36.71	2
3	Registered Nurses	19,050	21,099	702,996	33.32	3
4	Licensed Practical Nurses	45,328	48,771	1,342,203	27.52	4
5	CNAs & Orderlies	81,539	92,189	955,477	10.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,951	16,373	264,354	16.15	8
9	Activity Director	3,096	3,568	45,074	12.63	9
10	Activity Assistants	15,212	17,259	155,696	9.02	10
11	Social Service Workers	7,651	8,501	218,176	25.66	11
12	Dietician	1,971	2,096	36,781	17.55	12
13	Food Service Supervisor	1,881	2,152	53,452	24.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,510	6,417	70,307	10.96	15
16	Dishwashers	15,508	17,560	157,444	8.97	16
17	Maintenance Workers	5,427	6,050	119,775	19.80	17
18	Housekeepers	22,817	26,787	256,916	9.59	18
19	Laundry	7,268	8,329	77,721	9.33	19
20	Administrator	1,923	2,156	112,005	51.95	20
21	Assistant Administrator	1,950	2,196	54,276	24.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,816	10,278	209,235	20.36	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	3,104	3,653	58,872	16.12	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,888	2,098	33,230	15.84	33
34	TOTAL (lines 1 - 33)	267,603	301,768	$ 5,106,476 *	$ 16.92	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	331	$ 17,127	01-03	35
36	Medical Director	Monthly	24,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,181	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	Therapy Consultant	Per Visit	372	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	331	$ 48,180		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	53	$ 2,625	10-03	50
51	Licensed Practical Nurses	545	22,513	10-03	51
52	Certified Nurse Assistants/Aides	6,405	99,526	10-03	52
53	TOTAL (lines 50 - 52)	7,002	$ 124,664		53

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Stucker	Administrator	0	$ 112,005
Mary Boulos	Asst. Administrator	0	54,277
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 166,281

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
See Attached	Legal	$ 73,718
Allen A. Lefkovitz	R/E Tax Assessment	26,946
Paycor	Payroll Services	28,375
Access One	Data Processing	1,231
eHealth Data Solutions	MDS Software	3,180
Ability Network	Medicare Billing	3,347
AIS Assessment & Intelligence	MDS Consultant	1,319
National Datacare Corporation	Resident Fund Processing	1,612
Legat Architechts	Architecture Consultant	2,586
DIAWA - HFG	Line of Credit	9,180
Plante & Moran	Accounting	1,000
See Supplemental Schedule		549,420
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 701,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 210,544
Unemployment Compensation Insurance	59,070
FICA Taxes	390,646
Employee Health Insurance	209,195
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,455
Pension Expense	38,165
Other Employee Welfare	987
Holiday Expense	7,250
TOTAL (agree to Schedule V, line 22, col.8)	$ 921,311

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	6,278
Health Care Worker Background Check	5,245
(Indicate # of checks performed 353)	
Patient Background Checks	
Licenses and Permits	2,225
Dues and Subscriptions	26,678
Allocated - Ext. Care Consulting	952
Allocated - Ext Care Clinical	171
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,558
Allocated - Ext. Care Consulting	327
Allocated - Ext. Care Clinical	1,073
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,958

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/15 Ending: 12/31/15

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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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $22,898**

(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. $ **75,031** 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. $ **289,651**
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.