		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0040303

Facility Name: Prairie View Cr Ctr Lewistwn

Address: 175 East Sycamore (Number) Lewistown (City) 61542 (Zip Code)

County: Fulton

Telephone Number: (309) 547-2267 **Fax #** (309) 547-2272

HFS ID Number:

Date of Initial License for Current Owners: 2/1/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
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 1/1/16 to 12/31/16 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)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	Larry Templin Partner
	(Firm Name & Address)	Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525
	(Telephone)	(630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF	2,316	241	1,583	4,140	8
9	SNF/PED					9
10	ICF	14,676	76		14,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,992	317	1,583	18,892	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.14%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 2/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 1,372

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Prairie View Cr Ctr Lewistwn** **# 0040303** **Report Period Beginning: 1/1/16** **Ending: 12/31/16**

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	123,001	9,746	6,421	139,168		139,168		139,168			1
2	Food Purchase		127,129		127,129		127,129		127,129			2
3	Housekeeping	88,774	24,831		113,605		113,605		113,605			3
4	Laundry	52,679	24,598		77,277		77,277		77,277			4
5	Heat and Other Utilities			53,368	53,368		53,368	401	53,769			5
6	Maintenance	36,083	27,626	36,449	100,158		100,158	210	100,368			6
7	Other (specify):* **Waste Removal**			8,370	8,370		8,370		8,370			7
8	**TOTAL General Services**	300,537	213,930	104,608	619,075		619,075	611	619,686			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000		7,000			9
10	Nursing and Medical Records	1,158,226	126,754	16,269	1,301,249		1,301,249	45,530	1,346,779			10
10a	Therapy	32,252			32,252		32,252		32,252			10a
11	Activities	82,795		2,765	85,560		85,560		85,560			11
12	Social Services	64,332		8,696	73,028		73,028		73,028			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Alloc. Emp Benefits**							7,775	7,775			15
16	**TOTAL Health Care and Programs**	1,337,605	126,754	34,730	1,499,089		1,499,089	53,305	1,552,394			16
	C. General Administration											
17	Administrative	60,958		251,844	312,802		312,802	(219,346)	93,456			17
18	Directors Fees											18
19	Professional Services			66,340	66,340		66,340	2,094	68,434			19
20	Dues, Fees, Subscriptions & Promotions			5,811	5,811		5,811	773	6,584			20
21	Clerical & General Office Expenses	52,827	5,922	52,935	111,684		111,684	60,786	172,470			21
22	Employee Benefits & Payroll Taxes			247,016	247,016		247,016		247,016			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,054	6,054		6,054	4,589	10,643			24
25	Other Admin. Staff Transportation			6,749	6,749		6,749	2,251	9,000			25
26	Insurance-Prop.Liab.Malpractice			79,698	79,698		79,698	441	80,139			26
27	Other (specify):* **Alloc. Emp Benefits**							15,761	15,761			27
28	**TOTAL General Administration**	113,785	5,922	716,447	836,154		836,154	(132,651)	703,503			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,751,927	346,606	855,785	2,954,318		2,954,318	(78,735)	2,875,583			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn #0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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			60,000	60,000		60,000	92,221	152,221			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,526	24,526		24,526	(558)	23,968			32
33	Real Estate Taxes			22,200	22,200		22,200		22,200			33
34	Rent-Facility & Grounds			48,000	48,000		48,000	(44,570)	3,430			34
35	Rent-Equipment & Vehicles			7,210	7,210		7,210	3,012	10,222			35
36	Other (specify):*											36
37	TOTAL Ownership			161,936	161,936		161,936	50,105	212,041			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,447	226,949	301,396		301,396		301,396			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,200	160,200		160,200		160,200			42
43	Other (specify):* See Att Sch 4A			65,002	65,002		65,002	(56,048)	8,954			43
44	TOTAL Special Cost Centers		74,447	452,151	526,598		526,598	(56,048)	470,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,751,927	421,053	1,469,872	3,642,852		3,642,852	(84,678)	3,558,174			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Prairie View Cr Ctr Lewistwn

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			5,801	5,801		5,801		5,801			
	Radiology Expenses			3,153	3,153		3,153		3,153			
	Non-Allowable Expenses	10,199		44,048	54,247		54,247	(54,247)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	10,199	0	53,002	63,201	0	63,201	(54,247)	8,954			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(8,304)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	92,221	30		9
10	Interest and Other Investment Income	(558)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	43		13
14	Non-Care Related Interest	(24,934)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,187)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,000)	43		24
25	Fund Raising, Advertising and Promotional	(5,646)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(10,411)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (917)		$	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)	(83,761)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (83,761)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,678)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Prairie View Cr Ctr Lewistwn

ID# 0040303

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
2	Marketing Wages	(10,199)	21	1
2	Offset Miscellaneous Income Against Expense	(316)	21	2
3	Additional Repairs and Maintenance	104	6	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				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	(10,411)		49

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 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	32	Interest	$	Prairie View Care Center of Lewistown, LLC	100.00%	$ 24,934	$ 24,934	1
2	V	34	Rent-Facility & Grounds	48,000	Prairie View Care Center of Lewistown, LLC	100.00%		(48,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 48,000			$ 24,934	$ * (23,066)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	5	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 401	$ 401	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	106	106	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	45,530	45,530	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	7,775	7,775	18
19	V	17	Administrative	251,844	Certified Health Management, Inc.	100.00%	32,498	(219,346)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	3,281	3,281	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	773	773	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	71,301	71,301	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	4,589	4,589	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	2,251	2,251	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	441	441	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	15,761	15,761	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	3,430	3,430	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	3,012	3,012	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			$ 251,844			$ 191,149	$ * (60,695)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Bradley Alter & Beth Alter	37.085%	Glenwood Healthcare & Rehab	Glenwood	Prairie View Care	Skokie	Lessor	1
2	Howard A. Geller & Rita Geller	47.417%	Danville Care Center	Danville	Cte of Lewistown LLC			2
3	Laurence Zung	3.506%	Renaissance Care Center	Canton	Certified Health	Skokie	Management	3
4	Irene Sandler	2.768%	Paxton Healthcare and Rehab	Paxton	Management, Inc.			4
5	Ira Shyman	1.845%	Pontiac Healthcare and Rehab	Pontiac				5
6	Joseph L Ashman	1.845%						6
7	Rabbi Morris Noble	1.845%						7
8	Jennifer Chow	1.845%						8
9	Julie Brum	1.845%						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	3.81	9.53	Alloc. Salary	$ 4,824	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	3.81	9.53	Alloc. Salary	6,368	L21, C7	2
3	Bradley Alter	Owner	Administration	37.085	See Att Sch 7A	4.76	9.52	Alloc. Salary	17,625	L17, C7	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	$ 28,817		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: Certified Health Management, Inc.
Street Address: 3856 W. Oakton
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	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	5	Heat and Other Utilities	Census Days	198,295	6	$ 4,208	$	18,892	$ 401	1
2	6	Maintenance	Census Days	198,295	6	1,116		18,892	106	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	18,892	45,530	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		18,892	7,775	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	18,892	32,498	5
6	19	Professional Services	Census Days	198,295	6	34,439		18,892	3,281	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		18,892	773	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	18,892	71,301	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		18,892	4,589	9
10	25	Other Admin Staff Transportation	Census Days	198,295	6	23,623		18,892	2,251	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		18,892	441	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		18,892	15,761	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		18,892	3,430	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		18,892	3,012	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,006,356	$ 1,446,604		$ 191,149	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Renaissance Care Center LLC	X		Mortgage	$7,319.55		$ 3,028,781	$ 3,059,520			$ 24,934	1
2	Bank Leumi		X	Mortgage				477,313				2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				487,521			23,277	6
7	Insurance Financing										1,249	7
8												8
9	TOTAL Facility Related				$7,319.55		$ 3,028,781	$ 4,024,354			$ 49,460	9
	B. Non-Facility Related*											
10												10
11							Disallow Related Party Interest				(24,934)	11
12							Offset Interest Income				(558)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,492)	14
15	TOTALS (line 9+line14)						$ 3,028,781	$ 4,024,354			$ 23,968	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		$ 22,750	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.)	2015	$ 22,542	2
3. Under or (over) accrual (line 2 minus line 1).		$ (208)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 22,408	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.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	25,884	8
	2012	25,966	9
	2013	21,923	10
	2014	22,099	11
	2015	22,542	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie View Cr Ctr Lewistwn COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0040303

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-19-27-141-004	Long Term Care Property	$ 22,541.78	$ 22,541.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,541.78	$ 22,541.78

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			$ 148,500	1
2					2
3	TOTALS			$ 148,500	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	99			1976	$ 2,673,000	$	27.5	$ 97,200	$ 97,200	$ 1,563,214	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	24,124		20			24,124	9
10	Various			1994	16,141		20			16,141	10
11	Various			1995	1,113		20			1,113	11
12	Various			1997	15,843		20	792	792	15,434	12
13	Various			1998	8,800		20	440	440	8,358	13
14	Various			1999	21,882		20	1,094	1,094	19,101	14
15	Various			2001	11,953		20	598	598	9,749	15
16	Various			2002	1,750		20	88	88	1,269	16
17	Various			2003	11,023		20	551	551	7,303	17
18	Various			2004	13,699		20	685	685	8,562	18
19	Various			2005	9,041		20	452	452	5,286	19
20	Various			2006	18,227		20	911	911	9,606	20
21	Various			2007	14,892		20	745	745	7,230	21
22	Various			2008	30,045		20	1,502	1,502	22,091	22
23	Various			2010	35,192		20	1,760	1,760	11,950	23
24	Various			2011	2,650		20	133	133	718	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Water Heater	2012	$ 3,310	$	20	$ 166	$ 166	$ 828	37
38	A/C Compressor	2012	4,261		20	213	213	976	38
39	Rooftop Hvac Units	2012	10,630		20	532	532	2,348	39
40	Video Monitor System	2012	8,043		20	402	402	4,806	40
41	Security Systems	2013	3,017		20	151	151	1,408	41
42	Landscaping Phase 1 And Phase 2	2013	6,025		20	301	301	1,238	42
43	Ellsworth Glass & Aluminum - Windows	2013	3,043		20	152	152	520	43
44	Carpet Tile And Cornices - Dining Room	2013	3,978		20	199	199	696	44
45	New Ceiling & Wall, Ceiling Repairs - Room 301	2013	2,800		20	140	140	490	45
46	Heat Exchanger For Laundry	2013	3,852		20	193	193	1,220	46
47	Plaster Repairs	2014	2,795		20	140	140	303	47
48	New Alarm / Camera / Monitoring System	2014	3,259		20	163	163	462	48
49	Firewall Upgrade In 3 Areas	2014	2,500		20	125	125	260	49
50	Roof Repairs	2014	9,500		20	475	475	1,029	50
51	Installation Of A/C Unit In Dining Room	2015	5,725		20	286	286	429	51
52	Addition Of Blackflow In Existing System	2015	6,200		20	310	310	594	52
53	Window Replacement	2015	38,280		20	1,914	1,914	3,828	53
54	A/C Sleeve Openings	2015	26,582		20	1,329	1,329	2,658	54
55	Boiler Replacement	2015	84,675		20	4,234	4,234	8,468	55
56	Roof Repairs	2015	3,850		20	193	193	386	56
57	Doors, Frame And Panic Bars	2015	9,267		20	463	463	926	57
58	Install Air Handler and Connect to Duct Work-See P 12B Line 14	2016	14,600		20	730	730	730	58
59	Install Water Heaters (2)	2016	20,517		20	1,026	1,026	1,026	59
60	Install New Heat Exchanger on Boiler	2016	4,044		20	202	202	202	60
61									61
62									62
63									63
64									64
65									65
66									66
67	Financial Statement Depreciation			60,000			(60,000)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,190,128	$ 60,000		$ 120,990	$ 60,990	$ 1,767,080	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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		$ 3,190,128	$ 60,000		$ 120,990	$ 60,990	$ 1,767,080	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements (Real Estate Entity):								8
9	Asbestos Removal	2015	14,870		20	744	744	1,488	9
10	Facility Signage	2015	6,830		20	342	342	684	10
11	Refurbish 14 Doors For Painting	2015	4,620		20	231	231	462	11
12	Bathroom Remodeling- Doors, Paint, Walls	2015	20,647		20	1,032	1,032	2,064	12
13	A/C Units & Sleeves	2015	20,769		20	1,038	1,038	2,076	13
14	Install Air Handler and Connect to Duct Work-See P 12A Line 58	2016	9,545		20	477	477	477	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Allocated from Certified Health Management	1997	8,980		20			8,980	24
25	Allocated from Certified Health Management	2014	2,525		20	126	126	442	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,278,914	$ 60,000		$ 124,980	$ 64,980	$ 1,783,753	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 261,241	$	$ 26,124	$ 26,124	10	$ 153,686	71
72	Current Year Purchases	11,172		1,117	1,117	10	1,117	72
73	Fully Depreciated Assets	303,108				10	303,108	73
74								74
75	TOTALS	$ 575,521	$	$ 27,241	$ 27,241		$ 457,911	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		Vehicle	1996	$ 4,476	$	$	$	5	$ 4,476	76
77		Vehicle	1999	20,436				5	20,436	77
78										78
79										79
80	TOTALS			$ 24,912	$	$	$		$ 24,912	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)	$ 4,027,847	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,221	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 92,221	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,266,576	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				3,430			5
6								6
7	TOTAL				$ 3,430 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,210 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated from Management Co.			3,012	18
19					19
20					20
21	TOTAL		$	$ 3,012	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Prairie View Cr Ctr Lewistwn**
IDPH License ID Number: **0040303**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Storage	625
Copier	5,092
Dishwasher	1,493
Total - Line 16	**7,210**

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 101,375	$		$ 101,375	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			12,400			12,400	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			113,174	4,262		117,436	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				70,185		70,185	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 226,949	$ 74,447		$ 301,396	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ (116,492)	$ (107,551)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,541)	1,179,504	1,179,504	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,068	61,068	6
7	Other Prepaid Expenses	18,175	18,175	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Taxes on Deposit	381	381	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,142,636	$ 1,151,577	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		148,500	13
14	Buildings, at Historical Cost		2,673,000	14
15	Leasehold Improvements, at Historical Cost	385,207	605,914	15
16	Equipment, at Historical Cost	394,775	600,433	16
17	Accumulated Depreciation (book methods)	(553,057)	(2,266,576)	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 (spe LTC Mgmt Stock	28,987	28,987	22
23	Other(specify): Loan Costs		24,409	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 255,912	$ 1,814,667	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,398,548	$ 2,966,244	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,733	$ 407,733	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	487,521	487,521	29
30	Accrued Salaries Payable	102,397	102,397	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,356	5,356	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,408	22,408	32
33	Accrued Interest Payable	96,436	556,986	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Rent	58,188	58,188	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,180,039	$ 1,640,589	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,536,833	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	3,633,304	2,434,963	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,633,304	$ 5,971,796	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,813,343	$ 7,612,385	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,414,795)	$ (4,646,141)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,398,548	$ 2,966,244	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: **Prairie View Cr Ctr Lewistwn**
IDPH License ID Number: **0040303**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 43 Other Long-Term Liabilities (specify):

Description	Operating	After Consolidation
INTERCOMPANY PAYABLE	3,302,334	1,981,716
DUE TO SHAREHOLDERS	330,970	330,970
DUE TO HOWARD GELLER		122,277
Total - Line 43	**3,633,304**	**2,434,963**

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,907,873)	1
2	Restatements (describe): Bad Debt Expense		2
3	See Attached Schedule 18A	(192,002)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,099,875)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(314,920)	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)**	$ (314,920)	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)**	$ (3,414,795)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Prairie View Cr Ctr Lewistwn**
IDPH License ID Number: **0040303**
Fiscal Year End: **12/31/16**

Schedule 18A

XVI. Statement of Changes in Equity
Line 2 Restatements

Description	Amount
Bad Debt Expense	(191,433)
State Replacement Tax	(381)
Miscellaneous Difference	(188)
Total	**(192,002)**

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 3,264,188	1
2	Discounts and Allowances for all Levels	(22,632)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,241,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	81,522	6
7	Oxygen	(7,077)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 74,445	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,804	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,723	19
20	Radiology and X-Ray	530	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,057	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	558	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 558	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	316	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 316	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,327,932	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	619,075	31
32	Health Care	1,499,089	32
33	General Administration	836,154	33
	B. Capital Expense		
34	Ownership	161,936	34
	C. Ancillary Expense		
35	Special Cost Centers	366,398	35
36	Provider Participation Fee	160,200	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,642,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	(314,920)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (314,920)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,262,039	44
45	Private Pay - Net Inpatient Revenue	56,101	45
46	Medicare - Net Inpatient Revenue	634,249	46
47	Other-(specify) Managed Care	123,168	47
48	Other-(specify) Hospice	165,999	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,241,556	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,960	2,091	$ 68,482	$ 32.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,784	8,244	203,452	24.68	3
4	Licensed Practical Nurses	10,578	11,545	265,565	23.00	4
5	CNAs & Orderlies	42,097	45,034	565,431	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,362	2,495	32,252	12.93	8
9	Activity Director	1,720	1,990	21,621	10.86	9
10	Activity Assistants	5,750	6,089	61,174	10.05	10
11	Social Service Workers	1,928	2,081	33,088	15.90	11
12	Dietician					12
13	Food Service Supervisor	1,881	2,092	30,136	14.41	13
14	Head Cook	3,462	3,648	34,094	9.35	14
15	Cook Helpers/Assistants	6,120	6,368	58,771	9.23	15
16	Dishwashers					16
17	Maintenance Workers	1,848	2,052	36,083	17.58	17
18	Housekeepers	7,726	8,446	88,774	10.51	18
19	Laundry	5,467	5,833	52,679	9.03	19
20	Administrator	1,976	2,056	60,958	29.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,870	2,081	52,827	25.39	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	336	384	5,021	13.08	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	5,139	5,306	81,519	15.36	33
34	TOTAL (lines 1 - 33)	110,004	117,835	$ 1,751,927 *	$ 14.87	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	160	$ 6,421	L1,C3	35
36	Medical Director	Monthly	7,000	L9,C3	36
37	Medical Records Consultant	48	2,383	L10,C3	37
38	Nurse Consultant	Monthly	9,000	L10,C3	38
39	Pharmacist Consultant	Monthly	3,960	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	3,696	L12,C3	45
46	Other(specify) Psychiatric Cons.	Monthly	5,000	L12,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	244	$ 37,460		49

C. CONTRACT NURSES

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

Prairie View Cr Ctr Lewistwn

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,024	2,101	50,275	23.93
Transportation	3,115	3,205	31,244	9.75
				#DIV/0!
TOTAL	5,139	5,306	81,519	

Facility Name & ID Number Prairie View Cr Ctr Lewistwn # 0040303 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Lockwood	Administrator	0	$ 60,958
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,958

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 251,844
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 251,844

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 7,501
E-Health Data Solutions	Data Processing	974
PayChex	Payroll Service	20,563
On Shift	Data Processing	1,481
Ability Network	Data Processing	3,965
Personnel Planners	Unemployment Consulting	5,127
Wescom Solutions Inc	Data Processing	18,040
See Attached Legal Schedule	Legal Fees	8,689
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 66,340

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,483
Unemployment Compensation Insurance	22,048
FICA Taxes	130,138
Employee Health Insurance	47,102
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,710
Pension Plan Contribution	5,535
TOTAL (agree to Schedule V, line 22, col.8)	$ 247,016

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	589
Health Care Worker Background Check (Indicate # of checks performed 60)	601
Patient Background Checks	
Dues & Subscriptions	348
Licenses & Permits	293
Allocated from Management Co.	773
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,584

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,054
Allocated from Management Co.	4,589
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,643

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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? **None**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,889** 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. $ **160,200**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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