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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0046011

Facility Name: Prairie Manor Nursing & Rehab Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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: 01/01/17 Ending: 12/31/17

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	32,899	3,370	12,150	48,419	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,899	3,370	12,150	48,419	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.63%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 8,476

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	338,885	74,176	18,339	431,400		431,400	9,742	441,142			1
2	Food Purchase		300,744		300,744		300,744	316	301,060			2
3	Housekeeping	260,334	65,353		325,687		325,687	1,214	326,901			3
4	Laundry	87,235	24,272		111,507		111,507		111,507			4
5	Heat and Other Utilities			192,591	192,591		192,591	1,487	194,078			5
6	Maintenance	158,032		255,179	413,211		413,211	(2,267)	410,944			6
7	Other (specify):*							4,280	4,280			7
8	TOTAL General Services	844,486	464,545	466,109	1,775,140		1,775,140	14,772	1,789,912			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,000,804	273,903	671,189	3,945,896		3,945,896	41,252	3,987,148			10
10a	Therapy	294,161			294,161		294,161		294,161			10a
11	Activities	198,872	40,682		239,554		239,554		239,554			11
12	Social Services	221,580			221,580		221,580	34,433	256,013			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,862	10,862			15
16	TOTAL Health Care and Programs	3,715,417	314,585	707,189	4,737,191		4,737,191	86,547	4,823,738			16
	C. General Administration											
17	Administrative	168,578			168,578		168,578	103,051	271,629			17
18	Directors Fees											18
19	Professional Services			721,271	721,271	(11,714)	709,557	(581,145)	128,411			19
20	Dues, Fees, Subscriptions & Promotions			89,839	89,839		89,839	(36,554)	53,285			20
21	Clerical & General Office Expenses	254,740	58,679	613,598	927,017		927,017	(446,513)	480,504			21
22	Employee Benefits & Payroll Taxes			970,878	970,878		970,878	(4,274)	966,604			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,931	2,931		2,931	1,277	4,208			24
25	Other Admin. Staff Transportation			4,161	4,161		4,161	893	5,054			25
26	Insurance-Prop.Liab.Malpractice			355,054	355,054		355,054	2,249	357,303			26
27	Other (specify):*							36,981	36,981			27
28	TOTAL General Administration	423,318	58,679	2,757,732	3,239,729	(11,714)	3,228,015	(924,036)	2,303,979			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,983,221	837,809	3,931,030	9,752,060	(11,714)	9,740,346	(822,716)	8,917,629			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: 01/01/17 Ending: 12/31/17

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			140,239	140,239		140,239	158,229	298,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			426	426		426	206,292	206,718			32
33	Real Estate Taxes			651,959	651,959	11,714	663,673	4,518	668,191			33
34	Rent-Facility & Grounds			492,200	492,200		492,200	(492,000)	200			34
35	Rent-Equipment & Vehicles			6,282	6,282		6,282	987	7,269			35
36	Other (specify):*			1,022	1,022		1,022	(1,022)				36
37	**TOTAL Ownership**			1,292,128	1,292,128	11,714	1,303,842	(122,996)	1,180,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		361,097	1,324,294	1,685,391		1,685,391	(29,668)	1,655,723			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			320,540	320,540		320,540		320,540			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		361,097	1,644,834	2,005,931		2,005,931	(29,668)	1,976,263			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,983,221	1,198,906	6,867,992	13,050,119		13,050,119	(975,380)	12,074,739			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: 01/01/17 Ending: 12/31/17

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	(79,225)	30		9
10	Interest and Other Investment Income	(80,233)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(206)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(561,952)	21		24
25	Fund Raising, Advertising and Promotional	(27,895)	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	(120,416)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (869,927)		$	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)	(105,454)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (105,454)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (975,381)		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (8,641)	21	1
2	Jury Duty	(40)	10	2
3	Charitable Donations	(1,167)	20	3
4	Collection Expense	(5,617)	21	4
5	Amortization	(1,022)	36	5
6	PAC Dues	(9,309)	20	6
7	Building Company - Management Fees	(7,300)	21	7
8	Building Company - Filing Fee	(250)	21	8
9	Building Company - Amortization Expense	(5,034)	31	9
10	Non-Allowable Legal Fees	(65,684)	19	10
11	Capitalized R&M	(14,107)	06	11
12	Convenience fee	(11)	33	12
13	Non-Allowable Professional Fees	(2,233)	19	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**	(120,416)		49

Prairie Manor Nursing & Rehab Center

ID# 0046011

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			179		9,563							9,742	1
2	Food Purchase	(206)		522									316	2
3	Housekeeping			1,079		135							1,214	3
4	Laundry													4
5	Heat and Other Utilities			1,336		151							1,487	5
6	Maintenance	(14,107)		3,681	7,898	261							(2,267)	6
7	Other (specify):*				2,941	1,339							4,280	7
8	**TOTAL General Services**	(14,313)		6,797	10,839	11,449							14,772	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(40)				43,132		(1,840)					41,252	10
10a	Therapy													10a
11	Activities													11
12	Social Services					34,433							34,433	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,862							10,862	15
16	**TOTAL Health Care and Programs**	(40)				88,427		(1,840)					86,547	16
	C. General Administration													
17	Administrative			2,755	15,839	84,457							103,051	17
18	Directors Fees													18
19	Professional Services	(67,917)		(384,635)		(128,593)							(581,145)	19
20	Fees, Subscriptions & Promotions	(38,371)		800		1,017							(36,554)	20
21	Clerical & General Office Expenses	(583,760)	7,550	7,915	99,066	22,769		(53)					(446,513)	21
22	Employee Benefits & Payroll Taxes				(4,274)				(0)				(4,274)	22
23	Inservice Training & Education													23
24	Travel and Seminar			34		1,243							1,277	24
25	Other Admin. Staff Transportation			893									893	25
26	Insurance-Prop.Liab.Malpractice			1,611		638							2,249	26
27	Other (specify):*				22,202	14,779							36,981	27
28	**TOTAL General Administration**	(690,049)	7,550	(370,627)	132,833	(3,690)		(53)	(0)				(924,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(704,402)	7,550	(363,830)	143,672	96,186		(1,893)	(0)				(822,716)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(79,225)	234,711	2,291		452							158,229	30
31	Amortization of Pre-Op. & Org.	(5,034)	5,034											31
32	Interest	(80,233)	272,012	14,348		165							206,292	32
33	Real Estate Taxes	(11)		4,026		503							4,518	33
34	Rent-Facility & Grounds		(492,000)										(492,000)	34
35	Rent-Equipment & Vehicles			987									987	35
36	Other (specify):*	(1,022)											(1,022)	36
37	**TOTAL Ownership**	(165,525)	19,757	21,652		1,120							(122,996)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(29,668)					(29,668)	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**							(29,668)					(29,668)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(869,927)	27,307	(342,178)	143,672	97,306		(31,561)	(0)				(975,380)	45

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 492,000	Prairie Manor Property, LLC	100.00%	$	$ (492,000)	1
2	V	32	Interest Income	232	Prairie Manor Property, LLC	100.00%		(232)	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%	234,711	234,711	5
6	V	31	Amortization Expense		Prairie Manor Property, LLC	100.00%	5,034	5,034	6
7	V	32	Interest Expense - Providence		Prairie Manor Property, LLC	100.00%	272,244	272,244	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 492,232			$ 519,539	$ * 27,307	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: 01/01/17 Ending: 12/31/17

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%	$ 179	$ 179	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	522	522	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,079	1,079	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,336	1,336	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,681	3,681	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,755	2,755	20
21	V	19	Professional Fees	388,176	Extended Care Consulting, LLC	100.00%	3,541	(384,635)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	800	800	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	7,915	7,915	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	34	34	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	893	893	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,611	1,611	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,291	2,291	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	14,348	14,348	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,026	4,026	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	987	987	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			$ 45,998	$ * (342,178)	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: 01/01/17 Ending: 12/31/17

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%	7,898	$ 7,898	15
16	V	06	Maintenance (Direct)	14,246	Extended Care Consulting, LLC	100.00%	14,246		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	732	732	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,209	2,209	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	15,839	15,839	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	99,066	99,066	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%	22,202	22,202	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	4,274	Extended Care Consulting, LLC	100.00%		(4,274)	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			$ 18,520			$ 162,192	$ * 143,672	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: 01/01/17 Ending: 12/31/17

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%	$ 135	$ 135	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	151	151	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	261	261	17
18	V	19	Professional Fees	129,396	Extended Care Clinical, LLC	100.00%	803	(128,593)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,017	1,017	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,692	1,692	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,243	1,243	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	638	638	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	452	452	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	165	165	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	503	503	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,563	9,563	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,339	1,339	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	43,132	43,132	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	34,433	34,433	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,862	10,862	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	84,457	84,457	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	21,077	21,077	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	14,779	14,779	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,396			$ 226,702	$ * 97,306	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: 01/01/17 Ending: 12/31/17

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	Various Equipment	13,475	Vent Lease LLC	100.00%	13,475	$	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			$ 13,475			$ 13,475	$ *	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: 01/01/17 Ending: 12/31/17

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	22,273	MAC Rx, LLC	100.00%	20,433	(1,840)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services		MAC Rx, LLC	100.00%			17
18	V	21	Clerical & General Office Expenses	644	MAC Rx, LLC	100.00%	591	(53)	18
19	V	22	Employee Benefits		MAC Rx, LLC	100.00%			19
20	V	39	Ancillary	359,171	MAC Rx, LLC	100.00%	329,503	(29,668)	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			$ 382,088			$ 350,527	$ * (31,561)	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: 01/01/17 Ending: 12/31/17

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%	$ 227,921	$ 227,921	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	227,921	CCS Employee Benefits Group	100.00%		(227,921)	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			$ 227,921			$ 227,921	$ * (0)	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	CHICAGO HEIGHTS	BUILDING COMPANY	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	EVANSTON	BUILDING COMPANY	4
5	MELISSA ROTHNER ACCUM. TRUST	11.11 %	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	NATHAN & SHIRLEY ROTHNER TRUST	22.22 %	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	RACHEL ROTHNER ACCUM. TRUST	11.11 %	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	WILLIAM ROTHNER ACCUM. TRUST	11.11 %	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	Mark Steinberg	Relative	Administrative	0	See Attached	2.72	4.94%	Alloc Sal/Fee	$ 9,897	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	1.01	2.53%	Alloc Sal	1,751	22-7	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	$ 11,648		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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,476,506	37	$ 5,451	$	48,419	$ 179	1
2	02	Food	Patient Days	1,476,506	37	15,903		48,419	522	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		48,419	1,079	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		48,419	1,336	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		48,419	3,681	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		48,419	2,755	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		48,419	3,541	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		48,419	800	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		48,419	7,915	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		48,419	34	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		48,419	893	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		48,419	1,611	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		48,419	2,291	13
14	32	Interest	Patient Days	1,476,506	37	437,528		48,419	14,348	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		48,419	4,026	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		48,419	987	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 45,998	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	48,419	7,898	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		14,246	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		48,419	732	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			2,209	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	48,419	15,839	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	48,419	99,066	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		48,419	22,202	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,426,248	$ 4,601,481		$ 162,192	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	781,509	20	$ 2,174	$	48,419	$ 135	1
2	05	Utilities	Patient Days	781,509	20	2,440		48,419	151	2
3	06	Maintenance	Patient Days	781,509	20	4,212		48,419	261	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		48,419	803	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		48,419	1,017	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		48,419	1,692	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		48,419	1,243	7
8	26	Insurance	Patient Days	781,509	20	10,303		48,419	638	8
9	30	Depreciation	Patient Days	781,509	20	7,302		48,419	452	9
10	32	Interest	Patient Days	781,509	20	2,656		48,419	165	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		48,419	503	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	48,419	9,563	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		48,419	1,339	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	48,419	43,132	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	48,419	34,433	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		48,419	10,862	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	48,419	84,457	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	48,419	21,077	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		48,419	14,779	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 226,702	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10	Various Equipment	Direct Allocation						13,475	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					$	$		$ 13,475	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						20,433	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation							3
4	21	Clerical & General Office Expense	Direct Allocation						591	4
5	22	Employee Benefits	Direct Allocation							5
6	39	Ancillary	Direct Allocation						329,503	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					$	$		$ 350,527	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 227,921	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					$	$		$ 227,921	25

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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**		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	Providence Bank		X	Mortgage			$	$ 5,867,377			$ 272,244	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,867,377			$ 272,244	9
	B. Non-Facility Related*											
10	Allocated from EC - Consulting	X									14,348	10
11	Allocated from EC - Clinical	X									165	11
12	Interest Income		X								(80,233)	12
13	See Supplemental Schedule										194	13
14	TOTAL Non-Facility Related						$	$			$ (65,526)	14
15	TOTALS (line 9+line14)						$	$ 5,867,377			$ 206,718	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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 670,350	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.)		$ 649,552	2
3. Under or (over) accrual (line 2 minus line 1).		$ (20,798)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 677,275	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.)		$ 11,714	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.		$ 668,192	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	537,669	8
	2013	557,173	9
	2014	616,734	10
	2015	638,430	11
	2016	645,023	12

2017 Accrual= $645,023*1.05=$677,275

Allocated from Extended Care Consulting - $4,026

Allocated from Extended Care Clinical - $503

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 645,023.40	$ 645,023.40
2.	See Attached	Allocated from Care Center Bldg	$ 181,041.32	$ 4,025.96
3.	See Attached	Allocated from Care Center Bldg	$ 181,041.32	$ 502.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,007,106.04	$ 649,551.96

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			20,511	2
3	TOTALS			$ 480,375	3

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 234,711	39	$ 119,231	$ (115,480)	$ 1,779,510	4
5				2013	1,609,158		39	41,260	41,260	206,300	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	33,716		20	1,524	1,524	24,974	9
10	Various			2004	215,253		20	9,744	9,744	158,807	10
11	Various			2005	96,470		20	2,221	2,221	80,011	11
12	Various			2006	90,263		20	4,360	4,360	53,525	12
13	Various			2007	56,209		20	2,810	2,810	30,449	13
14	Various			2008	31,219		20	1,871	1,871	17,899	14
15	Various			2009	43,314		20	1,608	1,608	24,794	15
16	Various			2010	44,836		20	2,242	2,242	16,209	16
17	Various			2011	104,287		20	4,970	4,970	36,612	17
18	Various			2012	71,505		20	3,575	3,575	20,662	18
19	Various			2013	64,164		20	3,208	3,208	15,040	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: 01/01/17 Ending: 12/31/17

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)		100,313	1,495		1,495		67,228	68
69	Financial Statement Depreciation			140,239			(140,239)		69
70	TOTAL (lines 4 thru 69)		$ 7,210,708	$ 376,445		$ 200,120	$ (176,325)	$ 2,532,018	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: 01/01/17 Ending: 12/31/17

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		$ 7,210,708	$ 376,445		$ 200,120	$ (176,325)	$ 2,532,018	1
2	Installed Hot Water Coil & Pump Assembly	2014	15,382		20	769	769	3,076	2
3	Repair Heating System, Valve, Panel Guage, Thermostats, Transn	2014	4,215		20	211	211	825	3
4	Furnish & Install 4 Door Restrictors	2014	5,960		20	298	298	1,167	4
5	Replaced Cracked Coils On Air Unit	2014	41,310		20	2,066	2,066	8,090	5
6	Remove & Install 2 Mixing Valves	2014	4,439		20	222	222	869	6
7	Emergency Coil Repairs	2014	13,690		20	685	685	2,567	7
8	Furnish & Install 2 Faux Stucco Signs	2014	17,328		20	1,155	1,155	3,947	8
9	Replace Actuator For Outside Air Dampler For Air Handler	2014	9,149		20	457	457	1,410	9
10	Installed New Valves On Boiler	2014	3,933		20	197	197	754	10
11	Millwork, Patch Walls, Repair Floor, Updated Plumbing & Electr	2014	28,800		20	1,440	1,440	5,640	11
12	Excavated & Repaired Leak On Auxiliary Valve On Fire Hydrant	2014	3,250		20	163	163	582	12
13	Reception/Meeting Room- Ceilings, Wood Trim, Doors, Tile, Plum	2014	188,530		20	9,427	9,427	32,993	13
14	New Awnings	2015	6,100		20	305	305	890	14
15	Replaced 28Ft Of Pipes	2015	15,663		20	783	783	2,219	15
16	Generator Installation	2015	119,422		20	5,971	5,971	13,435	16
17	8 Wood Doors	2015	4,967		20	248	248	600	17
18	Walk-In Freezer Doors	2015	7,346		20	367	367	857	18
19	Flood Light And Fixtures	2015	4,600		20	230	230	556	19
20	Ice/Water Shield, Standing Seam Roof & Metal Gutters And Dowr	2015	15,653		20	783	783	2,348	20
21	4 Doors And Frames	2015	34,250		20	1,713	1,713	5,138	21
22	Installation Of Generator	2015	58,500		20	2,925	2,925	8,044	22
23	Replace Leaking Domestic Booster Pump On Hot Water Boiler	2015	2,761		20	138	138	368	23
24	Convection Base Heater	2016	7,485		20	374	374	655	24
25	Electrical Work (New Feed)	2016	14,877		20	744	744	930	25
26	Replaced Faulty Pneumatic Controls	2016	2,734		20	137	137	228	26
27	190 Nominal Ton Air-Cooled Compressor Chiller	2017	179,872		20	8,244	8,244	8,244	27
28	Paving Parking Lot	2017	123,505		20	6,350	6,350	6,350	28
29	Entrance Awning	2017	3,700		20	567	567	567	29
30	3 Shunt Trip Breakers - Tie To Fire Alarm	2017	3,966		20	83	83	83	30
31	Doors-Locker Room/Housekeeping/Utility/Stairwell	2017	5,381		20	90	90	90	31
32	Fire Dampers	2017	59,859		20	998	998	998	32
33	Fire Guard Ceiling Tiles-Entire Facility-Life Safety Requirements	2017	19,092		20	206	206	206	33
34	TOTAL (lines 1 thru 33)		$ 8,236,426	$ 376,445		$ 248,462	$ (127,983)	$ 2,646,742	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: 01/01/17 Ending: 12/31/17

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		$ 8,236,426	$ 376,445		$ 248,462	$ (127,983)	$ 2,646,742	1
2	Hvac-Replace Pneumatic Receiver With Digital Operator	2017	5,111		20	256	256	256	2
3	Boiler #2 Pump Replacement	2017	3,383		20	169	169	169	3
4	Fire Alarm Equipment	2017	5,613		20	281	281	281	4
5	Entrance Awning Ceiling Replacement	2017	3,500		20	175	175	175	5
6	Entrance Awning Rood Replacement	2017	13,300		20	665	665	665	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)		$ 8,267,333	$ 376,445		$ 250,008	$ (126,437)	$ 2,648,288	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: 01/01/17 Ending: 12/31/17

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		$ 8,267,333	$ 376,445		$ 250,008	$ (126,437)	$ 2,648,288	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)		$ 8,267,333	$ 376,445		$ 250,008	$ (126,437)	$ 2,648,288	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: 01/01/17 Ending: 12/31/17

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		$ 8,267,333	$ 376,445		$ 250,008	$ (126,437)	$ 2,648,288	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)		$ 8,267,333	$ 376,445		$ 250,008	$ (126,437)	$ 2,648,288	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: 01/01/17 Ending: 12/31/17

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									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: 01/01/17 Ending: 12/31/17

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
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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: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting-Care Center Bldg	2002	25,129	644	35	644		9,853	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,870	174	35	174		1,830	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,137	80	35	80		1,230	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	151	8	20	8		83	9
10	Allocated from Extended Care Consulting	2009	90	5	20	5		41	10
11	Allocated from Extended Care Consulting	2010	885	44	20	44		354	11
12	Allocated from Extended Care Consulting	2011	318	16	20	16		112	12
13	Allocated from Extended Care Consulting	2012	105	5	20	5		31	13
14	Allocated from Extended Care Consulting	2014	1,454	73	20	73		291	14
15	Allocated from Extended Care Consulting	2016	1,744	87	20	87		174	15
16									16
17	Allocated from Extended Care Consulting-Care Center Bldg	2002	20,758		20			20,758	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2003	24,463		20			24,463	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,215		20			1,215	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2009	219	11	20	11		99	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,105	105	20	105		421	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2015	346	17	20	17		112	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,366	68	20	68		137	23
24	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,369	118	20	118		118	24
25									25
26	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,591		20			2,591	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,054		20			3,054	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2005	152		20			152	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2009	27	1	20	1		12	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2014	255	13	20	13		51	30
31	Allocated from Extended Care Clinical - Care Center Bldg	2015	43	2	20	2		14	31
32	Allocated from Extended Care Clinical - Care Center Bldg	2016	171	9	20	9		17	32
33	Allocated from Extended Care Clinical - Care Center Bldg	2017	296	15	20	15		15	33
34	TOTAL (lines 1 thru 33)		$ 100,313	$ 1,495		$ 1,495	$	$ 67,228	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: 01/01/17 Ending: 12/31/17

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		$ 100,313	$ 1,495		$ 1,495	$	$ 67,228	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 100,313	$ 1,495		$ 1,495	$	$ 67,228	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: 01/01/17 Ending: 12/31/17

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	$ 264,156	$ 747	$ 47,960	$ 47,213	10	$ 194,057	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,586,374				10	1,586,374	73
74								74
75	TOTALS	$ 1,850,531	$ 747	$ 47,960	$ 47,213		$ 1,780,431	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 Extended Care Consulting		$ 5,918	$ 167	$ 167	$	5	$ 5,751	76
77		Allocated from Extended Care Clinical		3,183	332	332		5	3,183	77
78										78
79										79
80	TOTALS			$ 9,101	$ 499	$ 499	$		$ 8,934	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)	$ 10,607,340	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 377,691	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 298,466	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (79,225)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,437,653	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: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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. [X] 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	Storage				200			5
6								6
7	TOTAL				$ 200 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 7,269 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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 589,345	$		$ 589,345	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			110,571			110,571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			592,276			592,276	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				310,002		310,002	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					32,102	51,095		83,197	13
14	TOTAL			$		$ 1,324,294	$ 361,097		$ 1,685,391	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:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,047	$ 76,192	1
2	Cash-Patient Deposits	34,624	34,624	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,042,388	1,042,388	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	201,730	201,730	6
7	Other Prepaid Expenses	7,973	7,973	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	4,385,003	4,562,541	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,673,765	$ 5,925,448	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	1,668,926	1,768,926	15
16	Equipment, at Historical Cost	527,203	1,727,203	16
17	Accumulated Depreciation (book methods)	(1,294,365)	(5,348,963)	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): See Attached Schedule	1,448	37,943	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 903,212	$ 4,995,514	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,576,977	$ 10,920,962	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 599,789	$ 599,788	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,650	25,650	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,170	260,170	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,219	11,219	31
32	Accrued Real Estate Taxes(Sch.IX-B)	677,275	677,275	32
33	Accrued Interest Payable		22,738	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	226,976	226,976	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,801,079	$ 1,823,816	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,867,377	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)**	$	$ 5,867,377	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,801,079	$ 7,691,193	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,775,898	$ 3,229,769	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,576,977	$ 10,920,962	48

***(See instructions.)**

Facility Name & ID Number Prairie Manor Nursing & Rehab Center **#** 0046011 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,033,890	1
2	Restatements (describe):		2
3	Rounding	7	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,033,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,742,001	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)**	$ 1,742,001	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)**	$ 4,775,898	24 *

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 13,163,506	1
2	Discounts and Allowances for all Levels	(5,254,627)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,908,879	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,955,843	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,955,843	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	2,778	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,762,041	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,181	19
20	Radiology and X-Ray	13,846	20
21	Other Medical Services	3,638	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,838,484	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80,233	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80,233	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,681	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,792,120	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,775,140	31
32	Health Care	4,737,191	32
33	General Administration	3,239,729	33
	B. Capital Expense		
34	Ownership	1,292,128	34
	C. Ancillary Expense		
35	Special Cost Centers	1,685,391	35
36	Provider Participation Fee	320,540	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,050,119	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,742,001	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,742,001	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,272,087	44
45	Private Pay - Net Inpatient Revenue	812,351	45
46	Medicare - Net Inpatient Revenue	416,193	46
47	Other-(specify) Hospice	348,990	47
48	Other-(specify) Insurance	59,258	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,908,879	49

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

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

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

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,080	1,008	$ 55,089	$ 54.66	1
2	Assistant Director of Nursing	1,439	1,482	54,789	36.97	2
3	Registered Nurses	18,322	19,156	664,693	34.70	3
4	Licensed Practical Nurses	42,944	45,979	1,324,875	28.81	4
5	CNAs & Orderlies	56,987	60,039	810,164	13.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,476	13,011	294,161	22.61	8
9	Activity Director	2,844	2,890	41,245	14.27	9
10	Activity Assistants	14,154	14,422	157,627	10.93	10
11	Social Service Workers	8,120	8,634	221,580	25.66	11
12	Dietician					12
13	Food Service Supervisor	3,743	3,863	92,783	24.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,099	6,082	78,362	12.88	15
16	Dishwashers	14,625	16,062	167,740	10.44	16
17	Maintenance Workers	8,324	8,766	158,032	18.03	17
18	Housekeepers	20,660	21,178	260,334	12.29	18
19	Laundry	7,632	7,563	87,235	11.53	19
20	Administrator	1,906	1,996	117,720	58.97	20
21	Assistant Administrator	1,745	1,690	50,858	30.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,056	14,074	254,740	18.10	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	3,159	3,261	64,619	19.82	31
32	Other Health Care(specify)					32
33	Other(specify)	1,666	1,788	26,574	14.86	33
34	TOTAL (lines 1 - 33)	240,980	252,944	$ 4,983,220 *	$ 19.70	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	359	$ 18,339	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	359	$ 54,339		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 369	10-03	50
51	Licensed Practical Nurses	16	904	10-03	51
52	Certified Nurse Assistants/Aides	27,797	669,914	10-03	52
53	TOTAL (lines 50 - 52)	27,821	$ 671,187		53

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Stucker	Administrator	0	$ 117,720
Mary Boulos	Asst. Administrator	0	50,858
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 168,578

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
Ability	Medicare Billing	$ 6,416
Matrixcare	Data Processing	18,010
National Datacare Corporation	Resident Fund Processing	1,339
Access One	Data Processing	1,636
Paycor	Payroll Processing	26,991
RFMS Fees	Data Processing	350
Legal Fees	See Attached	91,752
Personnel Planners, Inc.	Unemployment Tax Consult.	1,770
Marcum	Accounting Fees	25,714
Pinnacle Quality Insight	Customer Satisfaction	2,656
Legat Architects, Inc	Architect	4,618
See Supplemental Schedule		540,020
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 721,272

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 277,575
Unemployment Compensation Insurance	38,354
FICA Taxes	371,762
Employee Health Insurance	234,251
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	55
Pension Expense	32,079
Other Employee Welfare	8,645
Holiday Expense	3,883
TOTAL (agree to Schedule V, line 22, col.8)	$ 966,604

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	$
Advertising: Employee Recruitment	17,005
Health Care Worker Background Check	
(Indicate # of checks performed 41)	5,408
Patient Background Checks	
Licenses and Permits	3,656
Dues and Subscriptions	25,399
Allocated from Extended Care Consulting	800
Allocated from Extended Care Clinical	1,017
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,285

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,931
Allocated from Extended Care Consulting	34
Allocated from Extended Care Clinical	1,243
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,208

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **ILCLTC $18,618.4**

(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. $ **96,286** 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. $ **320,540**
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. $ 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