



Facility Name & ID Number Prairie Estates# 0036277 Report Period Beginning: 10/01/02 Ending: 09/30/03

## 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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,379			5,379	13
14	TOTALS	5,379			5,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.11%D. How many bed-hold days during this year were paid by Public Aid?  
285 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO I. On what date did you start providing long term care at this location?  
Date started 09/15/90J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/31/91 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 09/30/03 Fiscal Year: 09/30/03

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

STATE OF ILLINOIS

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/02 Ending: 09/30/03

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	45,983	1,348	993	48,324	(41)	48,283	858	49,141		1
2	Food Purchase		25,826		25,826	(1,137)	24,689		24,689		2
3	Housekeeping	28,378	3,460		31,838		31,838	762	32,600		3
4	Laundry		605		605		605		605		4
5	Heat and Other Utilities			9,024	9,024		9,024		9,024		5
6	Maintenance		6,673	2,375	9,048		9,048	(704)	8,344		6
7	Other (specify):* <b>Garbage Pickup</b>			720	720		720		720		7
8	<b>TOTAL General Services</b>	74,361	37,912	13,112	125,385	(1,178)	124,207	916	125,123		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	97,685	2,643	4,488	104,816	(96)	104,720		104,720		10
10a	Therapy			424	424	(42)	382		382		10a
11	Activities	25,309	590		25,899		25,899		25,899		11
12	Social Services	1,777			1,777		1,777		1,777		12
13	Nurse Aide Training	2,574	91		2,665		2,665		2,665		13
14	Program Transportation			1,662	1,662	(1,544)	118		118		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	127,345	3,324	6,574	137,243	(1,682)	135,561		135,561		16
	<b>C. General Administration</b>										
17	Administrative	45,801			45,801		45,801		45,801		17
18	Directors Fees							1,750	1,750		18
19	Professional Services			91,200	91,200		91,200	2,062	93,262		19
20	Dues, Fees, Subscriptions & Promotions			1,222	1,222		1,222		1,222		20
21	Clerical & General Office Expenses	13,414	1,445	2,275	17,134		17,134	3,069	20,203		21
22	Employee Benefits & Payroll Taxes			61,903	61,903	1,137	63,040		63,040		22
23	Inservice Training & Education			156	156	179	335		335		23
24	Travel and Seminar			246	246		246		246		24
25	Other Admin. Staff Transportation			1,216	1,216		1,216	1,732	2,948		25
26	Insurance-Prop.Liab.Malpractice			5,297	5,297		5,297	1,090	6,387		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	59,215	1,445	163,515	224,175	1,316	225,491	9,703	235,194		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	260,921	42,681	183,201	486,803	(1,544)	485,259	10,619	495,878		29

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

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

Facility Name &amp; ID Number

Prairie Estates

#0036277

Report Period Beginning:

10/01/02

Ending:

09/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			21,614	21,614		21,614	871	22,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,062	23,062		23,062	(4,631)	18,431			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			720	720		720		720			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			45,396	45,396		45,396	(1,360)	44,036			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					1,544	1,544		1,544			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,379	34,379		34,379		34,379			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			34,379	34,379	1,544	35,923		35,923			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	260,921	42,681	262,976	566,578		566,578	9,259	575,837			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 Estates

# 0036277

Report Period Beginning: 10/01/02

Ending: 09/30/03

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				9
10	Interest and Other Investment Income	(4,631)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Deferred Maintenance</u>	(1,900)	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (6,531)		\$	30

OHF 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	2	
		Amount	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)	15,790	See 8a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 15,790		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 9,259		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.	X		\$ 1,544	38
39			X		39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 1,544	47

Prairie Estates

ID# 0036277

Report Period Beginning: 10/01/02

Ending: 09/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred maintenance	\$ (1,900)	6	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				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	<b>Total</b>	(1,900)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Prairie Estates

# 0036277

Report Period Beginning:

10/01/02

Ending:

09/30/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,900)	0	0	0	0	0	0	0	0	0	0	(1,900)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,900)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,900)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,900)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,900)</b>	<b>29</b>



Facility Name & ID Number Prairie Estates

# 0036277

Report Period Beginning:

10/01/02

Ending:

09/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		<u>Our Place</u>	<u>Murphysboro</u>	<u>(Marion County</u>	<u>Salem</u>	<u>Home Office</u>
		<u>Richland Manor</u>	<u>Olney</u>	<u>Horizon Center)</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	<u>See attached 8a</u>	\$	<u>Marion County Horizon Center</u>	<u>0.00%</u>	\$ <u>15,790</u>	\$	<u>15,790</u>	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$ <u>15,790</u>	\$ *	<u>15,790</u>	14

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

Facility Name & ID Number      Prairie Estates      #      0036277      Report Period Beginning:      10/01/02      Ending:      09/30/03

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Angela Simmons	Director	Board Member	0.00	1,733	1.5	3.33	Director Fee	\$ 867	L18,C7	1
2	Bernadine Rankin	Director	Board Member	0.00	834	1	3.00	Director Fee	416	L18,C7	2
3	Susan Wieldt	Director	Board Member	0.00	933	1	3.00	Director Fee	467	L18,C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,750		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 Estates # 0036277 Report Period Beginning: 10/01/02 Ending: 09/30/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Marion County Horizon Center  
 Street Address 122 North Paragon Drive P.O. Box 745  
 City / State / Zip Code Salem, IL 62881  
 Phone Number (618) 548-0309  
 Fax Number (618) 548-3720

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

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	See attached 8a								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

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		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	American Ntnl Bank		X	Purchase Facility	\$4,161.00	07/31/91	\$ 441,700	\$ 226,032	08/15/10	9.7000	\$ 23,062	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	Interest income Prairie Estates										(4,545)	6								
7	Interest income from Home Office										(86)	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$4,161.00		\$ 441,700	\$ 226,032			\$ 18,431	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 441,700	\$ 226,032			\$ 18,431	15								

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

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

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

Facility Name & ID Number Prairie Estates# 0036277 Report Period Beginning: 10/01/02 Ending: 09/30/03

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

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2002 report.			\$	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.)			\$	2														
3.	Under or (over) accrual (line 2 minus line 1).			\$	3														
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6														
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:		1998	8	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR OHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	
<b>Non-profit received real estate tax exemption in 1992.</b>																			

## NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Prairie Estates COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0036277

CONTACT PERSON REGARDING THIS REPORT Angela Simmons

TELEPHONE (618) 548-0309 FAX #: (618) 548-3720

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

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,514 B. General Construction Type: Exterior Vinyl Frame Wood & Brick Number of Stories One

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>29,092</u>	<u>1991</u>	<u>\$ 7,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>29,092</b>		<b>\$ 7,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1991	1986	\$ 392,196	\$ 15,688	25	\$ 15,688	\$	\$ 190,869
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Landscaping		1986	4,294		10			4,294
10	Walk and Driveway		1986	2,738	137	20	137		2,293
11	Decorating		1986	300		5			300
12	Carpet and Tile		1987	1,014		6			1,014
13	Drapes		1987	770		6			770
14	Landscaping		1991	1,111		10			1,111
15	Paving/Concrete		1991	11,838	592	20	592		7,202
16	Wood deck		1991	1,174	78	15	78		952
17	Garage		1991	13,672	911	15	911		11,165
18	Landscaping		1991	2,369		10			2,369
19	Flooring		1994	1,721	115	15	115		1,109
20	Landscaping		1995	1,435	144	10	144		1,208
21	Vinyl Flooring		1998	3,468	231	15	231		1,252
22	Roof replacement (shingles)		2003	8,715	73	20	73		73
23	Replace decking & substructure		2003	4,640	39	20	39		39
24	Bathroom remodeling		2003	6,845	29	20	29		29
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$	\$	37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	<b>TOTAL (lines 4 thru 69)</b>			\$ 458,300	\$ 18,037		\$ 18,037	\$	\$ 226,049	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 47,959	\$ 2,006	\$ 2,006	\$	10	\$ 38,998	71
72	Current Year Purchases	1,208	35	35		10	35	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 49,167	\$ 2,041	\$ 2,041	\$		\$ 39,033	75

D. Vehicle Depreciation (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	Facility Transportation	1999 Dodge Van	1999	\$ 23,106	\$ 2,407	\$ 2,407	\$	4	\$ 23,106	76
77										77
78										78
79										79
80	TOTALS			\$ 23,106	\$ 2,407	\$ 2,407	\$		\$ 23,106	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)	\$ 537,573	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,485	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,485	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 288,188	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Jack Woods

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office	1987		03/09/92	720	5	0	5
6								6
7	TOTAL				\$ 720			7

10. Effective dates of current rental agreement:

Beginning 03/09/92

Ending 09/30/08

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

Fiscal Year Ending      Annual Rent

12. 09/30/04      \$ 720

13. 09/30/05      \$ 720

14. 09/30/06      \$ 720

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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	Facility Transportation	1998 GMC Jimmy	\$ 200.00	\$ 2,400	17
18					18
19					19
20					20
21	TOTAL		\$ 200.00	\$ 2,400	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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>50</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		91		91
3	Classroom Wages (a)		700		700
4	Clinical Wages (b)		1,120		1,120
5	In-House Trainer Wages (c)		754		754
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 2,665	\$	\$ 2,665
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,665		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$ N/A		\$	\$		\$	#VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	<b>TOTAL</b>			\$		\$	\$		\$	#VALUE!	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **Prairie Estates** # **0036277** Report Period Beginning: **10/01/02** Ending: **09/30/03**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **09/30/03** (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 189,881	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	79,822	3
4	Supply Inventory (priced at cost )	1,987	4
5	Short-Term Investments	115,863	5
6	Prepaid Insurance	2,065	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)	126,327	8
9	Other(specify): <u>Accrued interest receivable</u>	420	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 516,365	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	7,000	13
14	Buildings, at Historical Cost	405,868	14
15	Leasehold Improvements, at Historical Cost	52,433	15
16	Equipment, at Historical Cost	64,069	16
17	Accumulated Depreciation (book methods)	(282,372)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 246,998	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 763,363	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 5,033	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	15,600	30
31	Accrued Taxes Payable (excluding real estate taxes)	605	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36			36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 21,238	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable	226,032	41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 226,032	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 247,270	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 516,093	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 763,363	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 497,751	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 497,751	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	18,342	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 18,342	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 516,093	24 *

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 568,311	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 568,312	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,688	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,688	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,545	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,545	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Medical Transportation	1,544	28
28a	Unrealized gain on marketable securities	6,831	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,375	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 584,920	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	125,385	31
32	Health Care	137,243	32
33	General Administration	224,175	33
<b>B. Capital Expense</b>			
34	Ownership	45,396	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	34,379	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 566,578	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	18,342	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 18,342	43

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

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

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

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

Facility Name &amp; ID Number Prairie Estates

# 0036277

Report Period Beginning: 10/01/02

Ending:

09/30/03

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1			\$	\$	1
2					2
3	26	26	681	26.19	3
4					4
5					5
6	260	260	1,820	7.00	6
7					7
8					8
9	1,144	1,184	12,134	10.25	9
10	1,653	1,701	13,175	7.75	10
11	182	182	1,777	9.76	11
12					12
13					13
14	2,010	2,154	20,687	9.60	14
15	2,869	2,965	25,296	8.53	15
16					16
17					17
18	3,091	3,299	28,378	8.60	18
19					19
20	1,000	1,040	27,223	26.18	20
21					21
22	862	880	18,578	21.11	22
23					23
24	1,170	1,195	13,414	11.23	24
25					25
26	82	82	754	9.20	26
27					27
28	974	1,014	26,543	26.18	28
29					29
30	8,141	8,501	70,461	8.29	30
31					31
32					32
33					33
34	23,464	24,483	\$ 260,921 *	\$ 10.66	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	33	\$ 993	L1,C3	35
36				36
37				37
38				38
39	12	192	L10,C3	39
40				40
41				41
42				42
43	7	424	L10a,C3	43
44				44
45				45
46				46
47	48	3,600	L10,C3	47
48	12	696	L10,C3	48
49	112	\$ 5,905		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Trena Briscoe	Administrative	0	\$ 18,578	Workers' Compensation Insurance	\$ 4,099	IDPH License Fee	\$ 200	
Teresa J. Harrell	Admin,RN, QMRP	0	27,223	Unemployment Compensation Insurance	2,117	Advertising: Employee Recruitment	95	
				FICA Taxes	19,960	Health Care Worker Background Check	36	
				Employee Health Insurance	10,569	(Indicate # of checks performed <u>3</u> )		
				Employee Meals	1,137	IHCA dues	891	
				Illinois Municipal Retirement Fund (IMRF)*				
				SEP Retirement Plan (Employer Contribution)	24,981			
				Miscellaneous employee morale	177			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,801	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
			\$				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Krehbiel & Associates	Accounting*		\$ 2,062				Out-of-State Travel	\$
Health Care Management	Admin Consulting Fees		91,200				In-State Travel	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 93,262	TOTAL		\$	Seminar Expense	246
							Entertainment Expense ( )	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 246	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	Interior Painting	02/03	\$ 2,548	36 mo	\$	\$	\$	\$ 648	\$ 849	\$ 849	\$ 202	\$	\$	
2														
3														
4														
5														
6														
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8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 2,548		\$	\$	\$	\$ 648	\$ 849	\$ 849	\$ 202	\$	\$	

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. IHCA dues \$821 on line 20
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,379  
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? Yes 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 of Public Aid, 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. \$ 1,137 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,544  
c. What percent of all travel expense relates to transportation of nurses and patients? 58%  
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? N/A  
g. Does the facility transport residents to and from day training? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Krehbiel & Associates The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.