

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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.

I. IDPH Facility ID Number: 0012922

Facility Name: PRAIRIE VIEW HEALTHCARE

Address: 16827 1410 NORTH AVENUE PRINCETON 61356
 Number City Zip Code

County: BUREAU

Telephone Number: (815)875-1196 Fax # (815)872-4408

IDPA ID Number: 366006533001

Date of Initial License for Current Owners: 00/00/1961

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: CARLA PASCHAL Telephone Number: (815)625-5800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/02 to 11/30/03 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) <u>ADRIENNE ERICKSON</u>	
	(Title) <u>ADMINISTRATOR</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>SEE INDEPENDENT AUDITOR'S REPORT ATTACHED</u>	
	(Firm Name & Address) <u>CLIFTON GUNDERSON LLP</u> <u>3917 EAST LINCOLNWAY, SUITE A, STERLING, IL 6108</u>	
	(Telephone) <u>(815)625-5800</u> Fax # <u>(815)626-4386</u>	

MAIL TO: OFFICE OF HEALTH FINANCE
 ILLINOIS DEPARTMENT OF PUBLIC AID
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922 Report Period Beginning: 12/01/02 Ending: 11/30/03

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			2,529	2,529	8
9	SNF/PED					9
10	ICF	28,500	5,961		34,461	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,500	5,961	2,529	36,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.39%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1961

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 2,529

Medicare Intermediary AdminaStar Federal, Inc

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 11/30/03

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/02 Ending: 11/30/03

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
	A. General Services										
1	Dietary	203,301	18,081	5,283	226,665		226,665		226,665		1
2	Food Purchase		162,573		162,573	(6,612)	155,961	(4,838)	151,123		2
3	Housekeeping	112,195	15,282	3,510	130,987		130,987		130,987		3
4	Laundry	86,833	19,325		106,158		106,158		106,158		4
5	Heat and Other Utilities			95,403	95,403		95,403		95,403		5
6	Maintenance	56,614	5,157	41,311	103,082		103,082		103,082		6
7	Other (specify):* Admissions/Mktg	26,179			26,179		26,179		26,179		7
8	TOTAL General Services	485,122	220,418	145,507	851,047	(6,612)	844,435	(4,838)	839,597		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,570,041	115,944	36,079	1,722,064		1,722,064		1,722,064		10
10a	Therapy	56,706	401		57,107		57,107		57,107		10a
11	Activities	45,155	882	2,089	48,126		48,126		48,126		11
12	Social Services	34,405		435	34,840		34,840		34,840		12
13	Nurse Aide Training	1,607		11,703	13,310		13,310		13,310		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,707,914	117,227	50,306	1,875,447		1,875,447		1,875,447		16
	C. General Administration										
17	Administrative	60,000			60,000		60,000		60,000		17
18	Directors Fees			3,500	3,500		3,500		3,500		18
19	Professional Services			54,438	54,438		54,438		54,438		19
20	Dues, Fees, Subscriptions & Promotions			24,699	24,699		24,699	(17,757)	6,942		20
21	Clerical & General Office Expenses	89,255	7,346	38,656	135,257		135,257	(16,919)	118,338		21
22	Employee Benefits & Payroll Taxes			454,072	447,460	6,612	454,072		454,072		22
23	Inservice Training & Education										23
24	Travel and Seminar			925	925		925		925		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			103,900	103,900		103,900		103,900		26
27	Other (specify):*							2,436	2,436		27
28	TOTAL General Administration	149,255	7,346	680,190	830,179	6,612	836,791	(32,240)	804,551		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,342,291	344,991	876,003	3,556,673		3,556,673	(37,078)	3,519,595		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 VIEW HEALTHCARE

#0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,316	57,316		57,316	(2,847)	54,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,739	7,739		7,739		7,739			35
36	Other (specify):*											36
37	TOTAL Ownership			65,055	65,055		65,055	(2,847)	62,208			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			170,518	170,518		170,518		170,518			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,342	67,342		67,342		67,342			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			237,860	237,860		237,860		237,860			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,342,291	344,991	1,178,918	3,859,588		3,859,588	(39,925)	3,819,663			45

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

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	(4,838)	2		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	(2,847)	30		9
10	Interest and Other Investment Income				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	(17,757)	20		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	(27,743)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,185)		\$	30

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)	13,260	21,27	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,260		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (39,925)		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.			\$	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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

OHF USE ONLY

48		49		50		51		52	
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PRAIRIE VIEW HEALTHCARE

ID# 0012922

Report Period Beginning: 12/01/02

Ending: 11/30/03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	reimbursements-resident accounts	\$ (27,743)	21
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	Total	(27,743)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,838)	0	0	0	0	0	0	0	0	0	0	(4,838)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,838)	0	0	0	0	0	0	0	0	0	0	(4,838)	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(17,757)	0	0	0	0	0	0	0	0	0	0	(17,757)	20
21	Clerical & General Office Expenses	(27,743)	10,824	0	0	0	0	0	0	0	0	0	(16,919)	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	2,436	0	0	0	0	0	0	0	0	0	2,436	27
28	TOTAL General Administration	(45,500)	13,260	0	(32,240)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,338)	13,260	0	(37,078)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE# 0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(2,847)	0	0	0	0	0	0	0	0	0	0	(2,847)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,847)	0	0	0	0	0	0	0	0	0	0	(2,847)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(53,185)	13,260	0	0	0	0	0	0	0	0	0	(39,925)	45

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
Bureau County, Illinois	100%					

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	21	County Treasurer Office	\$	Bureau County, Illinois	100.00%	\$ 1,615	\$ 1,615	1
2	V	21	County Clerk Office		Bureau County, Illinois	100.00%	9,209	9,209	2
3	V	27	Treasurers-payroll taxes		Bureau County, Illinois	100.00%	124	124	3
4	V	27	Clerk-payroll taxes		Bureau County, Illinois	100.00%	705	705	4
5	V	27	Treasurers-health insurance		Bureau County, Illinois	100.00%	193	193	5
6	V	27	Clerks-health insurance		Bureau County, Illinois	100.00%	1,267	1,267	6
7	V	27	Treasurers-IMRF		Bureau County, Illinois	100.00%	22	22	7
8	V	27	Clerks-IMRF		Bureau County, Illinois	100.00%	125	125	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$				\$ 13,260	\$ * 13,260	14

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/02 Ending: 11/30/03

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending: 11/30/03

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 Bureau County, Illinois
 Street Address 700 S. Main Street
 City / State / Zip Code Princeton, IL 61356
 Phone Number (815)872-3241
 Fax Number (815)879-4803

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	County Treasurer Office	direct hours	4,160	2	\$ 60,528	\$ 60,528	111	\$ 1,615	1
2	21	County Clerk Office	direct hours	4,160	2	52,624	52,624	728	9,209	2
3	27	Treasurers-payroll taxes	7.65% of alloc salary	4,160	2	4,630		111	124	3
4	27	Clerks-payroll taxes	7.65% of alloc salary	4,160	2	4,026		728	705	4
5	27	Treasurers-health insurance	\$1.74/hour allocated	4,160	2	7,238		111	193	5
6	27	Clerks-health insurance	\$1.74/hour allocated	4,160	2	7,238		728	1,267	6
7	27	Treasurers-IMRF	1.36% of alloc salary	4,160	2	823		111	22	7
8	27	Clerks-IMRF	1.36% of alloc salary	4,160	2	716		728	125	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					\$ 137,823	\$ 113,152		\$ 13,260	25

Facility Name & ID Number

PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	N/A						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2002 report.

\$ **N/A** **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).

\$ **#VALUE!** **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.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **#VALUE!** **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

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

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 VIEW HEALTHCARE COUNTY BUREAU

FACILITY IDPH LICENSE NUMBER 0012922

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,745 B. General Construction Type: Exterior CONCRETE/BRICK Frame _____ Number of Stories THREE

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				\$	1
2					2
3	TOTALS			\$	3

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	123		1961	\$ 1,254,886	\$	35	\$	\$	\$ 1,254,885	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1962	11,272		40			11,272	9
10	Various		1971	2,057		40	51	51	1,686	10
11	Various		1972	2,907		40	73	73	2,334	11
12	Various		1973	934		40	23	23	724	12
13	Various		1974	1,172		40	29	29	871	13
14	Various		1975	1,207		40	30	30	871	14
15	Various		1976	4,845		40	121	121	3,399	15
16	Various		1979	34,833		40	871	871	21,775	16
17	Various		1980	11,724		40	293	293	7,032	17
18	Various		1981	123,199		40	3,080	3,080	65,905	18
19	Various		1982	108,830		40	2,721	2,721	61,994	19
20	Various		1983	33,664		40	842	842	17,675	20
21	Various		1984	18,550		20	918	918	18,550	21
22	Various		1985	26,319		20	1,316	1,316	25,004	22
23	Various		1987	5,075		20	254	254	4,315	23
24	Various		1988	13,173		20	659	659	10,544	24
25	Various		1989	51,234		20	2,562	2,562	38,430	25
26	Various		1990	16,786		20	839	839	11,746	26
27	Various		1992	24,562		20	1,229	1,229	14,133	27
28	Various		1993	35,494		20	3,417	3,417	29,666	28
29	Various		1995	114,757		20	6,013	6,013	49,402	29
30	Various		1996	11,479		20	662	662	4,659	30
31	Various		1997	11,369		20	596	596	3,388	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 VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	1998	1,523		20	152	152	760	38
39	1999	1,046		20	105	105	433	39
40	1999	1,134		20	113	113	461	40
41	1999	2,061		20	206	206	841	41
42	2000	1,656		20	76	76	304	42
43	2000	6,068		20	506	506	2,328	43
44	2000	1,018		20	45	45	180	44
45	2000	620		20	83	83	332	45
46	2000	540		20	72	72	288	46
47	2000	945		20	79	79	316	47
48	2000	524		20	35	35	140	48
49	2000	666		20	11	11	44	49
50	2000	1,694		20	283	283	1,132	50
51	2000	14,183		20	50	50	200	51
52	2000	3,595		20	90	90	360	52
53	2000	980		20	49	49	147	53
54	2001	824		20	69	69	207	54
55	2001	922		20	20	20	60	55
56	2001	2,310		20	39	39	117	56
57	2001	7,192		20	160	160	480	57
58	2001	1,100		20	28	28	84	58
59	2001	5,718		20	127	127	381	59
60	2001	3,450		20	115	115	345	60
61	2001	14,624		20	122	122	366	61
62	2001	500		20	4	4	12	62
63	2001	2,310		20	29	29	87	63
64	2001	3,450		20	108	108	324	64
65	2002	17,674		20	884	884	884	65
66	2002	37,184		20	1,859	1,859	1,859	66
67	2003	6,700		20	335	335		67
68	2003	3,154		20	158	158		68
69								69
70		\$ 2,065,693	\$		\$ 32,611	\$ 32,611	\$ 1,673,732	70

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning:

12/01/02

Ending:

11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 2,065,693	\$		\$ 32,611	\$ 32,611	\$ 1,673,732	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	FINANCIAL STATEMENT DEPRECIATION			57,316			(57,316)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,065,693	\$ 57,316		\$ 32,611	\$ (24,705)	\$ 1,673,732	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,065,693	\$ 57,316		\$ 32,611	\$ (24,705)	\$ 1,673,732	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		\$ 2,065,693	\$ 57,316		\$ 32,611	\$ (24,705)	\$ 1,673,732	34

**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	\$ 199,975	\$	\$ 19,998	\$ 19,998	10	\$ 107,981	71
72	Current Year Purchases	7,599		760	760	10	760	72
73	Fully Depreciated Assets	421,125					421,125	73
74								74
75	TOTALS	\$ 628,699	\$	\$ 20,758	\$ 20,758		\$ 529,866	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	Transport Residents	Van	2002	\$ 5,500	\$	\$ 1,100	\$ 1,100	5	\$ 2,200	76
77										77
78										78
79										79
80	TOTALS			\$ 5,500	\$	\$ 1,100	\$ 1,100		\$ 2,200	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)	\$ 2,699,892	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 57,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,469	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,847)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,205,798	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: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 7,739 Description: \$6617 copier rental and \$1122 oxygen tank rentals

(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

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. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>90</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 2,899	\$	\$ 2,899
2	Books and Supplies		311		311
3	Classroom Wages (a)		5,370		5,370
4	Clinical Wages (b)		4,380		4,380
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		350		350
9	TOTALS	\$	\$ 13,310	\$	\$ 13,310
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,310		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (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	39-03	hrs	\$		\$ 80,941	\$		\$ 80,941	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			6,788			6,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			82,789			82,789	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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	TOTAL			\$		\$ 170,518	\$		\$ 170,518	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.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning: 12/01/02

Ending:

11/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/03

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 347,668	\$	1
2	Cash-Patient Deposits	22,427		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	470,162		3
4	Supply Inventory (priced at)	6,761		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 847,018	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,254,886		14
15	Leasehold Improvements, at Historical Cost	755,939		15
16	Equipment, at Historical Cost	616,936		16
17	Accumulated Depreciation (book methods)	(2,181,601)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 446,160	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,293,178	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 114,447	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,427		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,743		30
31	Accrued Taxes Payable (excluding real estate taxes)			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
	Other Current Liabilities(specify):			
36	<u>Due to other funds</u>	2,126,651		36
37	<u>Compensated Absences</u>	27,394		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,319,662	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,319,662	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,026,484)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,293,178	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,343,104)	1
2	Restatements (describe):		2
3	Equity Adjustment - Correction to prior year fixed assets	51,495	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,291,609)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	265,125	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)	\$ 265,125	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)	\$ (1,026,484)	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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,978,848	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,978,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	715	13
14	Non-Patient Meals	11,450	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,165	23
	D. Non-Operating Revenue		
24	Contributions	10,266	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,266	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Fundraising revenue</u>	16,034	28
28a	<u>Operating transfers</u>	107,400	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 123,434	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,124,713	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	851,047	31
32	Health Care	1,875,447	32
33	General Administration	830,179	33
	B. Capital Expense		
34	Ownership	65,055	34
	C. Ancillary Expense		
35	Special Cost Centers	237,860	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,859,588	40
41	Income before Income Taxes (line 30 minus line 40)**	265,125	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 265,125	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 VIEW HEALTHCARE

0012922

Report Period Beginning: 12/01/02

Ending: 11/30/03

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	Director of Nursing	1,866	1,950	\$ 50,750	\$ 26.03	1
2	Assistant Director of Nursing	665	718	16,558	23.06	2
3	Registered Nurses	8,954	9,367	132,426	14.14	3
4	Licensed Practical Nurses	22,036	23,440	389,196	16.60	4
5	Nurse Aides & Orderlies	73,824	76,208	819,968	10.76	5
6	Nurse Aide Trainees	312	312	1,607	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,589	4,450	56,706	12.74	8
9	Activity Director	1,695	1,950	22,595	11.59	9
10	Activity Assistants	2,965	3,264	22,560	6.91	10
11	Social Service Workers	3,294	3,556	34,405	9.68	11
12	Dietician					12
13	Food Service Supervisor	1,860	1,950	26,961	13.83	13
14	Head Cook	6,884	7,434	52,537	7.07	14
15	Cook Helpers/Assistants	10,427	11,032	73,644	6.68	15
16	Dishwashers	1,912	2,163	19,122	8.84	16
17	Maintenance Workers	4,047	4,381	56,641	12.93	17
18	Housekeepers	13,463	15,315	112,195	7.33	18
19	Laundry	11,229	12,305	86,833	7.06	19
20	Administrator	1,796	1,951	60,000	30.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,882	1,950	30,733	15.76	23
24	Clerical	4,380	4,878	40,093	8.22	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	1,716	1,747	14,236	8.15	31
32	Other Health Care(specify)					32
33	Other(specify)	18,432	19,772	222,525	11.25	33
34	TOTAL (lines 1 - 33)	197,228	210,093	\$ 2,342,291 *	\$ 11.15	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	113	\$ 4,747	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,400	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	510	11-03	44
45	Social Service Consultant	8	435	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	130	\$ 8,092		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	429	\$ 16,332	10-03	50
51	Licensed Practical Nurses	562	19,205	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	991	\$ 35,537		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	
Adrienne Erickson	Administrator		\$ 60,000	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance	5,692	Advertising: Employee Recruitment	6,144	
				FICA Taxes	172,000	Health Care Worker Background Check (Indicate # of checks performed <u>26</u>)	312	
				Employee Health Insurance	240,226	Advertising	265	
				Employee Meals	6,612	Fundraising	6,364	
				Illinois Municipal Retirement Fund (IMRF)*	29,542	Public Relations	11,128	
						Dues	486	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,000			Less: Fundraising	(6,364)	
B. Administrative - Other						Less: Public Relations Expense	(11,128)	
Description			Amount			Non-allowable advertising	(265)	
			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 454,072	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,942	
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
Frost,Ruttenberg&Rothblatt	Accounting		\$ 51,748			\$	Out-of-State Travel	\$
Patricia Pratt	Medicare Consultant		1,515					
Computer Medic	Computer Assistance		675				In-State Travel	75
Centerline Technologies	Computer Assistance		500					
							Seminar Expense	850
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 54,438	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 925

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE

0012922

Report Period Beginning: 12/01/02

Ending: 11/30/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political 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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,562 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,342
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 6,612 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
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? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not completed as of 03/31/04
- (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

**PRAIRIE VIEW HOME
MEDICAID COST REPORT
FYE 11/30/03**

**Schedule V
Page 3, Line 27, Column 7**

Alloc Payroll Taxes (County Treasurers and Clerks)	829.00
Alloc Health Insurance (county Treasurers and Clerks)	1,460.00
Alloc IMRF (County Treasurers and Clerks)	<u>147.00</u>
Total	<u>2,436.00</u>

**PRAIRIE VIEW HOME
 MEDICAID COST REPORT
 FYE 11/30/03**

**Schedule XVIII - A
 Page 20, Line 33**

	# of hours	# of hours	Reporting Period	Average
	<u>actually worked</u>	<u>paid and accrued</u>	<u>Total Salaries/ Wages</u>	<u>Hourly Wage</u>
Runners	3,377	3,465	18,988	5.48
Rehab Director	2,168	2,481	51,446	20.74
Dietary Janitor	3,999	4,480	31,038	6.93
Nursing Office	1,644	1,659	13,373	8.06
Alzheimers	1,857	1,950	25,268	12.96
MDS/Careplan Coordinator	1,717	1,880	37,804	20.11
Admissions/Marketing	1,837	1,950	26,179	13.43
Staff Development Coordinator	<u>1,833</u>	<u>1,907</u>	<u>18,429</u>	9.66
Total	<u>18,432</u>	<u>19,772</u>	<u>\$222,525</u>	

**PRAIRIE VIEW HOME
MEDICAID COST REPORT
FYE 11/30/03**

**Schedule XIX - G
Page 21 - Schedule of Travel and Seminar**

Mileage:

12/10/2002	travel to meeting	H. Mattern-Dietary Cook	\$	21.60
5/13/2003	travel to board meeting	K. Mason-Activity Director		32.70
9/17/2003	seminar travel	K. Mason-Activity Director		<u>20.54</u>
				74.84

Seminars:

2/6/2003	Frost, Ruttenberg & Rothblatt HIPPA Seminar	A. Erickson-Administrator		125.00
2/24/2003	VP Circle of Quality, Inc.-Training for MDS	S. Hansen - Assit. Dir. Of Nursing		175.00
3/3/2003	IVADA Meeting	K. Mason-Activity Director		40.00
3/24/2003	Adminastar Federal-Medicare	J. Grady-Administration		50.00
3/28/2003	WCIAAAA Seminar-Alzheimers	K. Ketchmark - Nursing		15.00
9/17/2003	Greenfield - Convention for Activities	K. Mason-Activity Director		174.72
12/11/2003	OCC-Training for MDS	L. Hammerick-Dir. Of Nursing		<u>270.00</u>
				849.72

\$ 924.56

**PRAIRIE VIEW HOME
MEDICAID COST REPORT
FYE 11/30/03**

Schedule XIII

Page 15 - Training in other facility programs

Illinois Valley Community College
Oglesby, Illinois

cost paid per aide: \$414