

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

<p>I. IDPH Facility ID Number: <u>0045245</u></p> <p>Facility Name: <u>Prairie Rose Health Care Center</u></p> <p>Address: <u>900 South Chestnut Street</u> <u>Pana</u> <u>62557</u> Number City Zip Code</p> <p>County: <u>Christian</u></p> <p>Telephone Number: <u>(217) 562-3996</u> Fax # <u>(217) 562-4005</u></p> <p>HFS ID Number: <u>431710785001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/00</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> Limited Liability Co. <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. <u> </u>		<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center

0045245 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,931	4,531	2,478	25,940	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,931	4,531	2,478	25,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.73%

D. How many bed-hold days during this year were paid by the Department? 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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 03/01/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/1995 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 25 and days of care provided 2,478

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	182,226	14,508	31,333	228,067		228,067		228,067		1
2	Food Purchase		144,168		144,168		144,168	(14,261)	129,907		2
3	Housekeeping	113,905	11,261		125,166		125,166		125,166		3
4	Laundry	15,029	23,016		38,045		38,045		38,045		4
5	Heat and Other Utilities			88,077	88,077		88,077		88,077		5
6	Maintenance	24,337	6,566	39,750	70,653		70,653		70,653		6
7	Other (specify):*										7
8	TOTAL General Services	335,497	199,519	159,160	694,176		694,176	(14,261)	679,915		8
	B. Health Care and Programs										
9	Medical Director			21,750	21,750		21,750		21,750		9
10	Nursing and Medical Records	1,083,604	223,723	3,781	1,311,108		1,311,108	(3,044)	1,308,064		10
10a	Therapy	157,792		217,572	375,364		375,364		375,364		10a
11	Activities	25,731		3,123	28,854		28,854		28,854		11
12	Social Services	44,020	104		44,124		44,124		44,124		12
13	CNA Training										13
14	Program Transportation	3,867			3,867		3,867		3,867		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,315,014	223,827	246,226	1,785,067		1,785,067	(3,044)	1,782,023		16
	C. General Administration										
17	Administrative	72,593		221,800	294,393		294,393		294,393		17
18	Directors Fees										18
19	Professional Services			98,904	98,904		98,904	(68,931)	29,973		19
20	Dues, Fees, Subscriptions & Promotions			2,435	2,435		2,435		2,435		20
21	Clerical & General Office Expenses	77,771	6,904	22,480	107,155		107,155	(138)	107,017		21
22	Employee Benefits & Payroll Taxes			289,624	289,624		289,624	4,679	294,303		22
23	Inservice Training & Education			65	65		65		65		23
24	Travel and Seminar			135	135		135		135		24
25	Other Admin. Staff Transportation			20,200	20,200		20,200		20,200		25
26	Insurance-Prop.Liab.Malpractice			49,806	49,806		49,806		49,806		26
27	Other (specify):*										27
28	TOTAL General Administration	150,364	6,904	705,449	862,717		862,717	(64,390)	798,327		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,800,875	430,250	1,110,835	3,341,960		3,341,960	(81,695)	3,260,265		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

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	
	D. Ownership											
30	Depreciation			131,574	131,574		131,574		131,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			225,717	225,717		225,717		225,717			32
33	Real Estate Taxes			44	44		44	(44)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,517	39,517		39,517		39,517			35
36	Other (specify):*											36
37	TOTAL Ownership			396,852	396,852		396,852	(44)	396,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,127		69,127		69,127		69,127			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):* Nonallowable Cost	19,938	491	144,072	164,501		164,501	(164,501)				43
44	TOTAL Special Cost Centers	19,938	69,618	210,320	299,876		299,876	(164,501)	135,375			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,820,813	499,868	1,718,007	4,038,688		4,038,688	(246,240)	3,792,448			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(856)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(835)	43		18
19	Entertainment				19
20	Contributions	(583)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,932)	43		24
25	Fund Raising, Advertising and Promotional	(5,156)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(112,878)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (246,240)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (246,240)		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	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (8,887)	43	1
2	X-Rays - Part A	(460)	43	2
3	Special events costs	(1,063)	43	3
4	Offset nonresident meal income	(8,739)	2	4
5	Offset vending revenue	(843)	2	5
6	Legal Settlement Cost	(68,931)	19	6
7	Nonallowable real estate	(44)	33	7
8	Misc Income - Med Supplies	(3,044)	10	8
9	Misc Income - Office Supplies	(138)	21	9
10	Marketing Salaries	(19,938)	43	10
11	Marketing Supplies	(491)	43	11
12	Donations	(300)	43	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	(112,878)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Rose Health Care Center# 0045245

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	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	(9,582)	0	0	0	0	0	0	0	0	0	0	(9,582)	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	(9,582)	0	(9,582)	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	(3,044)	0	0	0	0	0	0	0	0	0	0	(3,044)	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	CNA 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	(3,044)	0	(3,044)	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	(68,931)	0	0	0	0	0	0	0	0	0	0	(68,931)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(138)	0	0	0	0	0	0	0	0	0	0	(138)	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	TOTAL General Administration	(69,069)	0	(69,069)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(81,695)	0	(81,695)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0	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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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):*	(164,501)	0	0	0	0	0	0	0	0	0	0	(164,501)	43
44	TOTAL Special Cost Centers	(164,501)	0	0	0	0	0	0	0	0	0	0	(164,501)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(246,240)	0	0	0	0	0	0	0	0	0	0	(246,240)	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
SJL Health Systems, Inc.	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	N/A	\$	N/A		\$	\$	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		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie Rose Health Care Center**

0045245 Report Period Beginning: **01/01/06** Ending: **12/31/06**

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 N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	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									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

SEE ACCOUNTANTS' COMPILATION REPORT

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	AMI Capital, Inc.		X	Mortgage	\$21,167.65	12/01/02	\$ 3,580,869	\$ 3,429,361	11/01/35	0.0618	\$ 213,100	1				
2	Amortization of Bond Issuance Expense			Bond							12,617	2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$21,167.65		\$ 3,580,869	\$ 3,429,361			\$ 225,717	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 3,580,869	\$ 3,429,361			\$ 225,717	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

** 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 2005 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.)	2005	\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2006 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.		\$		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	N/A	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>28,000</u>	<u>1995</u>	<u>\$ 13,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	28,000		\$ 13,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	121	1995	1976	\$ 1,068,665	\$ 35,622	30	\$ 35,622	\$	\$ 421,528
5									
6									
7									
8									
Improvement Type**									
9	1986 Additions		1986	970,363	32,345	30	32,345		649,603
10	1987 Additions		1987	110,922	3,825	29	3,825		72,409
11	1989 Additions		1989	2,219		10			2,219
12	1990 Additions		1990	4,295	143	30	143		3,841
13	1991 Additions		1991	134,283		7			134,283
14	1992 Additions		1992	17,130		7			17,130
15	1993 Additions		1993	24,239		7			24,239
16	1994 Additions		1994	10,559		7			10,559
17	1995 Additions		1995	14,617	974	15	974		11,138
18	1996 Additions		1996	305,057	25,421	12	25,421		(104,740)
19	1997 Additions		1997	23,542	2,354	10	2,354		21,472
20	Whirlpool bath		1998	9,120	912	10	912		8,208
21	Lift, bath trolley		1998	3,850	385	10	385		3,465
22	Shower room		1998	4,884	488	10	488		4,355
23	Entrance doors		1998	2,358	118	20	118		973
24	Curtains		1998	6,102		5			6,102
25	Sidewalk & pad		1999	1,484	99	15	99		750
26	Divide receipts on emergency generator		1999	2,397	120	20	120		899
27	Med room cabinets, counter top		1999	2,008	100	20	100		703
28	Heat/Cool		2000	1,876	268	7	268		1,697
29	Door alarms		2001	1,215	81	15	81		459
30	Dining room, living room, shower remodel		2001	94,315	3,144	30	3,144		17,553
31	Wooded doors		2001	1,900	127	15	127		644
32	Landscaping - renovation project		2001	1,174	117	10	117		785
33	Bituminous parking lot		2001	22,030	2,754	8	2,754		13,999
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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Replace plumbing fixtures	2002	\$ 2,490	\$ 125	20	\$ 125		\$ 623	37
38	Therapy room remodel	2002	5,617	281	20	281		1,264	38
39	Remodel medication/utility rooms	2002	7,909	395	20	395		1,779	39
40	2 heating/cooling rooftop units	2002	11,300	1,130	10	1,130		4,991	40
41	Breakroom remodel	2002	3,106	311	10	311		1,372	41
42	Exterior window covering	2002	7,650	1,093	7	1,093		4,736	42
43	Lights for therapy room	2002	805	81	10	81		329	43
44	Renovation on facility floors and walls	2002	36,842	1,842	20	1,842		7,522	44
45	Fire Supression System	2004	1,540	154	10	154		321	45
46	Antenna	2004	2,944	294	10	294		834	46
47	Sign	2004	1,200	120	10	120		240	47
48	Carpet	2005	1,281	256	5	256		469	48
49	Sidewalks	2006	8,735	467		467		467	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	TOTAL (lines 4 thru 69)		\$ 2,932,023	\$ 115,947		\$ 115,947	\$	\$ 1,349,221	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 689,594	\$ 15,119	\$ 15,119	\$	3-15	\$ 614,133	71
72	Current Year Purchases	15,838	508	508		10	508	72
73	Fully Depreciated Assets	58,744					58,744	73
74								74
75	TOTALS	\$ 764,176	\$ 15,627	\$ 15,627	\$		\$ 673,385	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	Van	1994	\$ 27,905	\$	\$	\$	7	\$ 27,905	76
77										77
78										78
79										79
80	TOTALS			\$ 27,905	\$	\$	\$		\$ 27,905	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)	\$ 3,737,604	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,574	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,574	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)	\$ 2,050,511	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			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: \$ 39,517 Description: Copier 4308, Dishwasher 666, MedaSTAT 2412, Accent HC 4489, Enloes Med 27643

(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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10a, 3	hrs	\$	1,267	\$ 101,106	\$	1,267	\$ 101,106	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		292	25,271		292	25,271	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,178	91,195		1,178	91,195	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				69,127		69,127	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Respiratory Therapy</u>	10a, 1 - 39, 3	9129 hours	157,792			0	9,129	157,792	13
14	TOTAL			\$ 157,792	2,737	\$ 217,572	\$ 69,127	11,866	\$ 444,491	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie Rose Health Care Center**

0045245

Report Period Beginning: **01/01/06**

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/06**

(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	\$ 600	\$ 600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>30,000</u>)	775,000	775,000	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,907	19,907	6
7	Other Prepaid Expenses	73,169	73,169	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	2,106	2,106	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 870,782	\$ 870,782	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,500	13,500	13
14	Buildings, at Historical Cost	2,864,931	2,932,023	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	859,173	792,081	16
17	Accumulated Depreciation (book methods)	(2,050,511)	(2,050,511)	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) <u>Financing Costs</u>	376,902	376,902	22
23	Other(specify): <u>See Schedule 17 A</u>	591,904	591,904	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,655,899	\$ 2,655,899	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,526,681	\$ 3,526,681	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 272,341	\$ 272,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	43,290	43,290	29
30	Accrued Salaries Payable	106,515	106,515	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,141	16,141	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,661	17,661	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	12,959	12,959	36
37	<u>Intercompany Payables</u>	709,743	709,743	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,178,650	\$ 1,178,650	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,386,071	3,386,071	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)	\$ 3,386,071	\$ 3,386,071	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,564,721	\$ 4,564,721	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,038,040)	\$ (1,038,040)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,526,681	\$ 3,526,681	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Prairie Rose Health Care Center
Facility # 0045245
January 1, 2006 - December 31, 2006

Schedule 17A

	<u>Operating</u>	<u>After Consolidation</u>
XV. BALANCE SHEET		
Line 23 - Other		
Replacement & Reserve Fund	249,458	249,458
Project fund-insurance	86,281	86,281
Completion Repair	235,643	235,643
MIP Reserve	20,522	20,522
	<u>591,904</u>	<u>591,904</u>

See Accountant's Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (979,709)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (979,709)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(58,332)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (58,331)	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)	\$ (1,038,040)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 3,341,557	1
2	Discounts and Allowances for all Levels	(212,933)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,128,624	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	391,958	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 391,958	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	93,006	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,739	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	168,076	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,102	19
20	Radiology and X-Ray		20
21	Other Medical Services	123,298	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 446,221	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,528	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,528	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending revenue	843	28
28a	Other (See Schedule 19A)	3,182	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,025	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,980,356	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	694,176	31
32	Health Care	1,785,067	32
33	General Administration	862,717	33
B. Capital Expense			
34	Ownership	396,852	34
C. Ancillary Expense			
35	Special Cost Centers	233,628	35
36	Provider Participation Fee	66,248	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,038,688	40
41	Income before Income Taxes (line 30 minus line 40)**	(58,332)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (58,332)	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.
This is not-for-profit entity.

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

Interest Income relates to Funded Depreciation, therefore it is not offset.

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

Prairie Rose Health Care Center
Facility # 0045245
January 1, 2006 - December 31, 2006

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Medical Supplies

3,044

Office Supplies

138

3,182

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,080	2,080	\$ 44,833	\$ 21.55	1
2	Assistant Director of Nursing	2,033	2,033	40,269	19.80	2
3	Registered Nurses	6,326	6,608	122,492	18.54	3
4	Licensed Practical Nurses	18,167	19,220	307,979	16.02	4
5	CNAs & Orderlies	56,771	59,980	537,051	8.95	5
6	CNA Trainees					6
7	Licensed Therapist	8,819	9,129	157,792	17.29	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,863	1,863	21,032	11.29	9
10	Activity Assistants	591	591	4,699	7.95	10
11	Social Service Workers	1,854	2,102	44,020	20.94	11
12	Dietician	2,057	2,057	42,532	20.67	12
13	Food Service Supervisor	3,971	3,971	48,700	12.26	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	11,213	11,896	90,994	7.65	15
16	Dishwashers					16
17	Maintenance Workers	2,029	2,093	24,337	11.63	17
18	Housekeepers	12,958	13,557	113,905	8.40	18
19	Laundry	1,797	1,946	15,029	7.73	19
20	Administrator	2,773	2,773	72,593	26.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,374	5,374	77,771	14.47	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					31
32	Other Health C: (See Sch 20A)	2,427	2,427	34,847	14.36	32
33	Other(specify) Marketing	1,961	1,985	19,938	10.04	33
34	TOTAL (lines 1 - 33)	145,063	151,684	\$ 1,820,813 *	\$ 12.00	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	131	\$ 31,333	2, 3	35
36	Medical Director	Monthly	21,750	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,000	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Rehab Cons.</u>	22	1,781	10, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	\$ 56,864		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Facility # 0045245
January 1, 2006 - December 31, 2006

Schedule 20A

XVIII. A. Staffing and Salary Costs - Line 32: Other Healthcare Costs

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary or Wages</u>	<u>Ave. Hrly. Wage</u>
Care Plan Coordinator	2,040	2,040	30,980	15.19
Transportation	387	387	3,867	9.99
	<u>2,427</u>	<u>2,427</u>	<u>34,847</u>	<u>14.36</u>

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	
Laura Morrell	Administrator	0	\$ 35,900	Workers' Compensation Insurance	\$ 64,800	IDPH License Fee	\$ 535	
Margaret West	Administrator	0	36,693	Unemployment Compensation Insurance	10,662	Advertising: Employee Recruitment	81	
				FICA Taxes	133,352	Health Care Worker Background Check (Indicate # of checks performed <u>150</u>)	1,500	
				Employee Health Insurance	65,838	<u>Above contains Patient & Employee BCs</u>	0	
				Employee Meals	4,679		0	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	319	
				Employee Retirement	2,823			
				Employee Relations	12,149			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,593			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fee			\$ 221,800					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 221,800	TOTAL (agree to Schedule V, line 22, col.8)		\$ 294,303	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,435
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
Ginoli & Company	Accounting		\$ 17,467				Out-of-State Travel	\$
Altschuler, Melvoin, Glasser	Accounting		8,450					
Settlement Law Suit	Legal (offset on Sch VI)		68,931	N/A			In-State Travel	
Sequoia Management	Other		1,359			0		
LTC Solutions	Computer Services		2,640				Seminar Expense	135
Misc Companies	Computer Services		57					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 98,904	TOTAL		\$ 0	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 135

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center# 0045245

Report Period Beginning:

01/01/06

Ending:

12/31/06**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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,030 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,248
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,679 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,739
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 16%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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. Audit current in progress
- (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? No, as legal fees are offset on Sch VI
Attach invoices and a summary of services for all architect and appraisal fees