

Facility Name & ID Number Prairie Rose Health Care Center

0045245 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,900	4,486	1,791	24,177	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,900	4,486	1,791	24,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.74%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

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 121 and days of care provided 1,791

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	189,668	18,230	3,195	211,093		211,093		211,093	1	
2	Food Purchase		141,338		141,338		141,338	(8,249)	133,089	2	
3	Housekeeping	113,347	15,171		128,518		128,518		128,518	3	
4	Laundry	18,637	15,456		34,093		34,093		34,093	4	
5	Heat and Other Utilities			117,598	117,598		117,598		117,598	5	
6	Maintenance	22,703	3,766	27,869	54,338		54,338		54,338	6	
7	Other (specify):*									7	
8	TOTAL General Services	344,355	193,961	148,662	686,978		686,978	(8,249)	678,729	8	
	B. Health Care and Programs										
9	Medical Director			21,500	21,500		21,500		21,500	9	
10	Nursing and Medical Records	1,022,472	157,354	1,767	1,181,593		1,181,593		1,181,593	10	
10a	Therapy	155,624	105	189,634	345,363		345,363		345,363	10a	
11	Activities	18,048	1,063	142	19,253		19,253		19,253	11	
12	Social Services	30,847	14		30,861		30,861		30,861	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,226,991	158,536	213,043	1,598,570		1,598,570		1,598,570	16	
	C. General Administration										
17	Administrative	104,400		215,800	320,200		320,200		320,200	17	
18	Directors Fees									18	
19	Professional Services			25,827	25,827		25,827		25,827	19	
20	Dues, Fees, Subscriptions & Promotions			6,381	6,381		6,381	(654)	5,727	20	
21	Clerical & General Office Expenses	70,044	4,403	77,256	151,703		151,703	(695)	151,008	21	
22	Employee Benefits & Payroll Taxes			271,886	271,886		271,886		271,886	22	
23	Inservice Training & Education			376	376		376		376	23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			10,224	10,224		10,224		10,224	25	
26	Insurance-Prop.Liab.Malpractice			38,502	38,502		38,502		38,502	26	
27	Other (specify):*									27	
28	TOTAL General Administration	174,444	4,403	646,252	825,099		825,099	(1,349)	823,750	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,745,790	356,900	1,007,957	3,110,647		3,110,647	(9,598)	3,101,049	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 Rose Health Care Center

#0045245

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			154,718	154,718		154,718	(9,748)	144,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			223,031	223,031		223,031	(5,976)	217,055			32
33	Real Estate Taxes			43	43		43	(43)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,555	26,555		26,555		26,555			35
36	Other (specify):*											36
37	TOTAL Ownership			404,347	404,347		404,347	(15,767)	388,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,216		57,216		57,216		57,216			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,249	66,249		66,249		66,249			42
43	Other (specify):* Non-allowable Cost	39,262	278	81,622	121,162		121,162	(121,162)				43
44	TOTAL Special Cost Centers	39,262	57,494	147,871	244,627		244,627	(121,162)	123,465			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,785,052	414,394	1,560,175	3,759,621		3,759,621	(146,527)	3,613,094			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.

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,892)	43	1
2	X-Rays-Part A	(1,265)	43	2
3	Resident Flower	(27)	43	3
4	Special Events	(1,020)	43	4
5	Offset Miscellaneous Revenue	(695)	21	5
6	Vending Machine Expense	(300)	43	6
7	Disallowed R.E. Tax	(43)	33	7
8	Disallowed Marketing Salaries	(39,262)	43	8
9	Disallowed Chamber of Commerce Dues	(654)	20	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	(49,158)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(8,249)	0	0	0	0	0	0	0	0	0	0	(8,249)	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	(8,249)	0	(8,249)	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	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	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	(654)	0	0	0	0	0	0	0	0	0	0	(654)	20
21	Clerical & General Office Expenses	(1,554)	0	0	0	0	0	0	0	0	0	0	(1,554)	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	(2,208)	0	(2,208)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,457)	0	(10,457)	29									

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(9,748)	0	0	0	0	0	0	0	0	0	0	(9,748)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,976)	0	0	0	0	0	0	0	0	0	0	(5,976)	32
33	Real Estate Taxes	(43)	0	0	0	0	0	0	0	0	0	0	(43)	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	(15,767)	0	(15,767)	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):*	(120,303)	0	0	0	0	0	0	0	0	0	0	(120,303)	43
44	TOTAL Special Cost Centers	(120,303)	0	(120,303)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(146,527)	0	(146,527)	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	None		None		

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		\$			\$	\$	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.

Prairie Rose Health Care Center
0045245

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 6A-Board of Directors

President

Mr. Michael Kuhl
Kuhl and Company
632 West Jefferson
Morton, Illinois 61550

Secretary

Mr. Daniel P. Gavin
Architectural Manager
Farnsworth Group, Inc.
7707 North Knoxville
Peoria, IL 61614

Treasurer

Ms. Kay L. Frank
Assistant Vice President
Associated Bank
125 N.E. Jefferson Avenue
Peoria, IL 61602

Director at Large

Dr. Michael A. Ahearn
Ahearn and Associates Medical Center
Arrow Towers North
513 Elliott Street
Kewanee, IL 61443

None of the Board members directly provided services to the nursing home

Michael Kuhl has ownership in Kuhl & Company and has provided services
insurance agent for the nursing home

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Rose Health Care Center**

0045245 Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	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

Facility Name & ID Number

Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	AMI Capital, Inc.		X	Mortgage	\$21,167.65	12/01/02	\$ 3,580,869	\$ 3,386,071	11/01/35	0.0618	\$ 210,499	1						
2												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	\$ 3,386,071			\$ 210,499	9						
B. Non-Facility Related*																		
10												10						
11							Amortization of Bond Issuance Cost				12,532	11						
12							Interest Revenue Offset				(5,976)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 6,556	14						
15	TOTALS (line 9+line14)						\$ 3,580,869	\$ 3,386,071			\$ 217,055	15						

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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 2006 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.)	2006	\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2007 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:	2002		8	
	2003		9	
	2004		10	
	2005		11	
	2006	N/A	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. <u>Not-For-Profit Entity. Does Not Pay Real Estate Taxes</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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).

N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 457,150	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions		1986		970,363	32,345	30	32,345		681,948	9
10	1987 Additions		1987		110,922	3,744	29	3,825	81	76,234	10
11	1989 Additions		1989		2,219		10			2,219	11
12	1990 Additions		1990		4,295	42	30	143	101	3,984	12
13	1991 Additions		1991		134,283		7			134,283	13
14	1992 Additions		1992		17,130		7			17,130	14
15	1993 Additions		1993		24,239		7			24,239	15
16	1994 Additions		1994		10,559		7			10,559	16
17	1995 Additions		1995		14,617	815	15	974	159	12,112	17
18	1996 Additions		1996		305,057	21,958	12	25,421	3,463	292,342	18
19	1997 Additions		1997		23,542	2,069	10	2,354	285	23,826	19
20	Whirlpool Bath		1998		9,120	912	10	912		9,120	20
21	Lift, Bath Trolley		1998		3,850	385	10	385		3,850	21
22	Shower Room		1998		4,884	488	10	488		4,843	22
23	Entrance Doors		1998		2,358	118	20	118		1,091	23
24	Curtains		1998		6,102		5			6,102	24
25	Sidewalk & Pad		1999		1,484	99	15	99		849	25
26	Divide Receipts on Emergency Generator		1999		2,397	120	20	120		1,019	26
27	Med Room Cabinets and Counter Top		1999		2,008	100	20	100		803	27
28	Heat/Cool		2000		1,876	179	7	268	89	1,965	28
29	Door Alarms		2001		1,215	81	15	81		540	29
30	Dining Room, Living Room, Shower Remodel		2001		94,315	3,413	30	3,144	(269)	20,697	30
31	Wooded Doors		2001		1,900	127	15	127		771	31
32	Landscaping-Renovation Project		2001		1,174	90	10	117	27	902	32
33	Bituminous Parking Lot		2001		22,030	2,754	8	2,754		16,753	33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

**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	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		\$ 748	37
38	Therapy Room Remodel	2002	5,617	281	20	281		1,545	38
39	Remodel Medication/Utility Rooms	2002	7,909	395	20	395		2,174	39
40	2 Heating/Cooling Roof Top Units	2002	11,300	1,130	10	1,130		6,121	40
41	Breakroom Remodel	2002	3,106	311	10	311		1,683	41
42	Exterior Window Covering	2002	7,650	1,093	7	1,093		5,829	42
43	Lights for Therapy Room	2002	805	81	10	81		410	43
44	Renovation on Facility Floors and Walls	2002	36,842	1,842	20	1,842		9,364	44
45	Fire Supression System	2004	1,540		10	154	154	475	45
46	Antenna	2004	2,944		10	294	294	1,128	46
47	Sign	2004	1,200		10	120	120	360	47
48	Carpet	2005	1,281	256	5	256		725	48
49	Sidewalks	2006	8,735	874	10	874		1,341	49
50	Duct Work	2007	5,120	149	15	171	22	171	50
51	Water Heater	2007	5,378	805	10	269	(536)	269	51
52	Sidewalks	2007	8,976	150	15	299	149	299	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)		\$ 2,951,497	\$ 112,953		\$ 117,092	\$ 4,139	\$ 1,837,973	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 705,432	\$ 19,889	\$ 16,703	\$ (3,186)	3-15	\$ 631,344	71
72	Current Year Purchases	223,501	21,876	11,175	(10,701)	10	11,175	72
73	Fully Depreciated Assets	58,744					58,744	73
74								74
75	TOTALS	\$ 987,677	\$ 41,765	\$ 27,878	\$ (13,887)		\$ 701,263	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	\$	\$	\$	5	\$ 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)	\$ 3,980,579	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,718	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,970	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,748)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,567,141	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	Specialized Unit	\$ 114,503	92
93			93
94			94
95		\$ 114,503	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 Original Lease Date	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: \$ 26,555 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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.

Prairie Rose Health Care Center

0045245

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 4,049
Dishwasher	729
Medical Equipment	21,552
Maintenance Equipment	<u>225</u>
	<u><u>26,555</u></u>

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$	5,901	\$ 88,512	\$	5,901	\$ 88,512	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		517	7,761		517	7,761	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,224	93,361	105	6,224	93,466	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 prescripts				57,216		57,216	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify): Respiratory Therapy	10A(1)	8584 hours		155,624			8,584	155,624	13	
14	TOTAL			\$	155,624	12,642	\$ 189,634	\$ 57,321	21,226	\$ 402,579	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.

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

0045245

Report Period Beginning: **01/01/2007**

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2007**

(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	\$ 149,140	\$ 149,140	1
2	Cash-Patient Deposits	38,635	38,635	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	555,443	555,443	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,774	21,774	6
7	Other Prepaid Expenses	55,489	55,489	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)	\$ 822,587	\$ 822,587	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,415	13,500	13
14	Buildings, at Historical Cost	2,842,209	1,068,665	14
15	Leasehold Improvements, at Historical Cost	1,281	1,882,832	15
16	Equipment, at Historical Cost	1,082,674	1,015,582	16
17	Accumulated Depreciation (book methods)	(2,205,230)	(2,567,141)	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>	464,406	464,406	22
23	Other(specify): <u>See Schedule 17A</u>	649,379	649,379	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,889,134	\$ 2,527,223	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,711,721	\$ 3,349,810	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 504,077	\$ 504,077	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	46,042	46,042	29
30	Accrued Salaries Payable	106,492	106,492	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,438	17,438	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	28,124	28,124	36
37	<u>Due to Tintera</u>	458,743	458,743	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,160,916	\$ 1,160,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,340,029	3,340,029	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to State of Illinois</u>	28,942	28,942	43
44	<u>Due to Manager</u>	251,000	251,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,619,971	\$ 3,619,971	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,780,887	\$ 4,780,887	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,069,166)	\$ (1,431,077)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,711,721	\$ 3,349,810	48

*(See instructions.)

**Prairie Rose Health Care Center
0045245**

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 17A

XV. Balance Sheet

Long Term Assets

Line 23 - Other Long-Term Assets

	Operating	After Consolidation
Replacement & Reserve Fund	253,178	253,178
Project Fund-Insurance	135,640	135,640
Completion Repair	238,308	238,308
MIP Reserve	22,253	22,253
Total Line 23 Other Long-Term Assets	649,379	649,379

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,038,040)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,038,039)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(31,127)	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)	\$ (31,127)	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)	\$ (1,069,166)	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	\$ 3,249,597	1
2	Discounts and Allowances for all Levels	(59,558)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,190,039	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,801	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 284,801	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,549	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,677	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	52,450	20
21	Other Medical Services	44,307	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 246,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,976	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	695	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 695	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,728,494	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	686,978	31
32	Health Care	1,598,570	32
33	General Administration	825,099	33
	B. Capital Expense		
34	Ownership	404,347	34
	C. Ancillary Expense		
35	Special Cost Centers	178,378	35
36	Provider Participation Fee	66,249	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,759,621	40
41	Income before Income Taxes (line 30 minus line 40)**	(31,127)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (31,127)	43

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

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,152	2,232	\$ 49,279	\$ 22.08	1
2	Assistant Director of Nursing	2,092	2,092	42,150	20.15	2
3	Registered Nurses	6,261	6,561	122,307	18.64	3
4	Licensed Practical Nurses	17,252	18,362	295,590	16.10	4
5	CNAs & Orderlies	51,481	53,528	481,467	8.99	5
6	CNA Trainees					6
7	Licensed Therapist	8,584	8,752	155,624	17.78	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,788	1,948	17,805	9.14	9
10	Activity Assistants	30	30	243	8.10	10
11	Social Service Workers	1,857	2,097	30,847	14.71	11
12	Dietician					12
13	Food Service Supervisor	6,240	6,240	95,456	15.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,398	12,005	94,212	7.85	15
16	Dishwashers					16
17	Maintenance Workers	1,733	1,901	22,703	11.94	17
18	Housekeepers	11,681	12,228	113,347	9.27	18
19	Laundry	2,219	2,474	18,637	7.53	19
20	Administrator	4,160	4,160	104,400	25.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,662	4,786	70,044	14.64	23
24	Clerical					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 Care(specify) <u>CPC</u>	2,040	2,040	31,679	15.53	32
33	Other(specify) <u>Marketing</u>	1,856	1,856	39,262	21.15	33
34	TOTAL (lines 1 - 33)	137,486	143,292	\$ 1,785,052 *	\$ 12.46	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	61	\$ 3,195	1(3)	35
36	Medical Director	Monthly	21,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	61	\$ 25,795		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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		
Laura Morrell	Administrator	0	\$ 36,400	Workers' Compensation Insurance	\$ 28,500	IDPH License Fee	\$ 995		
Margaret West	Administrator	0	68,000	Unemployment Compensation Insurance	1,411	Advertising: Employee Recruitment	290		
				FICA Taxes	131,205	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	90,941	Patient Background Checks	115		
				Employee Meals		Miscellaneous Dues & Subscriptions	654		
				Illinois Municipal Retirement Fund (IMRF)*		M.E.S. Dues	2,500		
				Employee Relations	15,664	Misc. License and Permit	792		
				Employee Retirement	3,980				
				Smoking Cessation	185				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,400	TOTAL (agree to Schedule V, line 22, col.8)			\$ 271,886		
B. Administrative - Other									
Description			Amount						
Management Fees			\$ 215,800				Less: Public Relations Expense (654)		
							Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 215,800				TOTAL (agree to Sch. V, line 20, col. 8) \$ 5,727		
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		\$ 8,950				Out-of-State Travel	\$	
RSM McGladrey	Accounting		9,680						
Sequoia Management	Legal Services		3,257	N/A			In-State Travel	0	
LTC Solutions	Computer Services		1,600						
Misc. Vendors	Computer Services		79				Seminar Expense		
E-Health Data Solutions	Computer Services		2,261						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,827	TOTAL			\$	Entertainment Expense () (agree to Sch. V, line 24, col. 8)	\$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Rose Health Care Center# 0045245Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. \$ 13,368 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,249
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,549
- (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? 0
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? N/A
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 currently 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 \$5,000, 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