

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0018044

Facility Name: PRAIRIEVIEW LUTHERAN HOME

Address: PO BOX 4, CORNER OF NORTH & 4TH DANFORTH 60930
 Number City Zip Code

County: IROQUOIS

Telephone Number: 815-269-2970 **Fax #** 815-269-2930

HFS ID Number: 362735789001

Date of Initial License for Current Owners: 2/14/74

Type of Ownership:

<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>501C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: CAROL PETERS **Telephone Number:** 815-269-2930

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

(Signed) _____ (Date) _____

Officer or Administrator of Provider
 (Type or Print Name) CAROL PETERS
 (Title) CEO/ADMINISTRATOR

(Signed) _____ (Date) _____

Paid Preparer
 (Print Name and Title) SHERILYN K RABIDEAU
CPA
 (Firm Name & Address) FOX CPA GROUP, LTD, 204 E CHERRY, SUITE 300
WATSEKA, IL 60970
 (Telephone) 815-432-3126 Fax # 815-432-6061

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044 Report Period Beginning: 1/1/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	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	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	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	<u>7,024</u>	<u>21,386</u>	<u>2,347</u>	<u>30,757</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,024</u>	<u>21,386</u>	<u>2,347</u>	<u>30,757</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.59%

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)

OUTPATIENT THERAPY

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 02/14/74

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 20 and days of care provided 2,347

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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	315,770	26,416	7,796	349,982		349,982	349,982			1
2	Food Purchase		224,367		224,367	(5,489)	218,878	218,878			2
3	Housekeeping	143,896	29,860		173,756		173,756	173,756			3
4	Laundry	70,388	11,901		82,289		82,289	82,289			4
5	Heat and Other Utilities			145,304	145,304		145,304	145,304			5
6	Maintenance	91,490	13,951	59,710	165,151		165,151	165,151			6
7	Other (specify):* MEDICAL WASTE					1,671	1,671	1,671			7
8	TOTAL General Services	621,544	306,495	212,810	1,140,849	(3,818)	1,137,031	1,137,031			8
	B. Health Care and Programs										
9	Medical Director			18,610	18,610	(13,810)	4,800	4,800			9
10	Nursing and Medical Records	2,013,810	227,838	4,371	2,246,019	(9,747)	2,236,272	(3,427)	2,232,845		10
10a	Therapy		1,385	210,922	212,307		212,307	212,307			10a
11	Activities	197,614	2,441	1,663	201,718		201,718	201,718			11
12	Social Services	30,900		270	31,170		31,170	31,170			12
13	CNA Training					3,361	3,361	3,361			13
14	Program Transportation					469	469	469			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,242,324	231,664	235,836	2,709,824	(19,727)	2,690,097	(3,427)	2,686,670		16
	C. General Administration										
17	Administrative	63,630			63,630		63,630	63,630			17
18	Directors Fees										18
19	Professional Services			58,631	58,631		58,631	58,631			19
20	Dues, Fees, Subscriptions & Promotions			58,918	58,918	1,930	60,848	(31,233)	29,615		20
21	Clerical & General Office Expenses	213,824	32,850	67,746	314,420	(1,930)	312,490	312,490			21
22	Employee Benefits & Payroll Taxes			835,302	835,302	24,287	859,589	859,589			22
23	Inservice Training & Education					2,395	2,395	2,395			23
24	Travel and Seminar			15,515	15,515	(3,137)	12,378	12,378			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			68,092	68,092		68,092	68,092			26
27	Other (specify):*										27
28	TOTAL General Administration	277,454	32,850	1,104,204	1,414,508	23,545	1,438,053	(31,233)	1,406,820		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,141,322	571,009	1,552,850	5,265,181		5,265,181	(34,660)	5,230,521		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 PRAIRIEVIEW LUTHERAN HOME #0018044 Report Period Beginning: 1/1/07 Ending: 12/31/07

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			200,146	200,146	200,146		200,146			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,700	19,700	19,700	(5,606)	14,094			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			219,846	219,846	219,846	(5,606)	214,240			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			25,418	25,418	25,418		25,418			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			50,370	50,370	50,370		50,370			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			75,788	75,788	75,788		75,788			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,141,322	571,009	1,848,484	5,560,815	5,560,815	(40,266)	5,520,549			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,427)	10		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	(5,606)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,187)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,075)	20		28
29	Other-Attach Schedule SUBSC/DUES	(971)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,266)		\$	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))	\$ (40,266)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
 PRAIRIEVIEW LUTHERAN HOME

ID# 0018044
 Report Period Beginning: 1/1/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,427)	0	0	0	0	0	0	0	0	0	0	(3,427)	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	(3,427)	0	0	0	0	0	0	0	0	0	0	(3,427)	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	(30,262)	0	0	0	0	0	0	0	0	0	0	(30,262)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(30,262)	0	0	0	0	0	0	0	0	0	0	(30,262)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,689)	0	0	0	0	0	0	0	0	0	0	(33,689)	29

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

Summary B

12/31/07

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	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	(5,606)	0	0	0	0	0	0	0	0	0	0	(5,606)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,606)	0	(5,606)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(39,295)	0	(39,295)	45									

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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
N/A						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending: 12/31/07

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

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	CAPITAL IMPROVEMENT		X	ADDITIONAL 32 BEDS	VARIES	3/21/96	\$ 1,500,000	\$ 255,000	09/01/10	0.0600	\$ 19,700	1								
2	REVENUE BOND SERIES											2								
3	1995 VILLAGE OF											3								
4	DANFORTH											4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,500,000	\$ 255,000			\$ 19,700	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,500,000	\$ 255,000			\$ 19,700	15								

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

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

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.)

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 PRAIRIEVIEW LUTHERAN HOME COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0018044

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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 PRAIRIEVIEW LUTHERAN HOME

0018044 Report Period Beginning:

1/1/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,200 B. General Construction Type: Exterior BRICK Frame STEEL & BRICK 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).

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: 11,892 2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: _____ 4. Dates Incurred: 1973

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>BLDG/GROUNDS</u>	<u>304,920</u>	<u>1971</u>	<u>\$ 9,115</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	304,920		\$ 9,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60			1973	\$ 549,963	\$ 13,749	40	\$ 13,749		\$ 466,746	4
5				1995	1,011,406	25,285	40	25,285		318,900	5
6	32			1996	1,834,874	45,872	40	45,872		489,301	6
7											7
8											8
Improvement Type**											
9		PLUMBING & HEATING & ELECTRICAL SYSTEM		1973	330,045		20			330,045	9
10		DRINKING FOUNTAIN EQUIPMENT		1978	2,180		15			2,180	10
11		BUILDING EQUIPMENT		1979	6,984		15			6,984	11
12		AIR CONDITIONER & COMPRESSOR		1980	9,184		20			9,184	12
13		ASPHALT DRIVE		1981	5,775		15			5,775	13
14		GARAGE/FIRE ALARM EQUIP/GRAVEL		1985	12,942		20			12,942	14
15		WINDOWS & DOOR		1986	1,445		15			1,445	15
16		WALLPAPER/LIGHTS/WATER HEATER		1987	5,839		VARIOUS			5,839	16
17		LANDSCAPING/LIGHTS/BOOSTER/HEATER		1988	7,120		VARIOUS			7,120	17
18		AIR CONDITIONING/RENOVATION/NURSES STATION		1989	237,555	10,748	VARIOUS	10,748		194,823	18
19		REMODELING		1991	3,303	132	25	132		2,216	19
20		PARKING LOT/SIDEWALK/PAVEMENT		1993	19,868		VARIOUS			19,868	20
21		TREATMENT PLANT		1994	225,522	11,276	20	11,276		148,468	21
22		WATER LINES		1995	16,234	1,082	15	1,082		13,706	22
23		TRENCH ELECTRICAL LINES		1995	751		10			751	23
24		SEWER DRAIN LINE		1995	517		10			517	24
25		STORM DRAIN		1995	8,181	545	15	545		8,141	25
26		WATER LINE UPGRADE		1995	10,630	266	40	266		3,191	26
27		PARKING LOT		1995	9,211	461	20	461		5,530	27
28		SIDEWALK		1995	19,696	985	20	985		11,819	28
29		GARAGE		1995	25,220	630	40	630		7,562	29
30		CONCRETE ENCLOSURE FOR DUMPSTER		1995	5,775	429	15	429		5,149	30
31		BUILDING IMPROVEMENTS FOR HALLWAY		1995	8,858		10			8,858	31
32		WALK IN COOLER		1995	12,936	862	15	862		11,021	32
33		WALK IN FREEZER		1995	12,935	862	15	862		11,021	33
34		BUILT IN CABINETS		1995	5,346		10			5,346	34
35		WINDOW TREATMENTS		1995	9,576		5			9,576	35
36		DOUBLE COMPARTMENT SINK		1995	2,015		10			2,015	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

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	LANDSCAPING	1995	\$ 772	\$	10	\$	\$	\$ 772	37
38	DRAINAGE TILE	1996	1,839	92	20	92		1,035	38
39	DRIVEWAY	1996	2,790	140	20	140		1,562	39
40	WINDOW TREATMENTS	1996	877		10			877	40
41	DOOR	1996	550		10			550	41
42	CARPET	1996	12,267		10			12,267	42
43	TILE FLOORING	1996	631		10			631	43
44	WATER METER	1996	1,397	70	20	70		781	44
45	DOOR	1996	758	17	10	17		758	45
46	WIND BREAK FOR DOOR	1996	708		10			708	46
47	WIRING FOR SEWER PLANT	1996	1,219		10			1,219	47
48	CHAPEL PARTITION	1996	6,350	159	40	159		1,907	48
49	ARCHITECT	1996	14,500	362	40	362		4,150	49
50	LANDSCAPING	1997	5,268	493	15	493		5,003	50
51	PARKING LOT LIGHTS	1997	1,869	125	15	125		1,260	51
52	CARPET & BASE-HALLWAYS	1997	4,481	136	10	136		4,481	52
53	WALLPAPER HALLWAYS	1997	11,838	1,037	10	1,037		11,838	53
54	LAUNDRY AREA RENOVATIONS	1997	2,327	101	10	101		2,327	54
55	WINDOW TREATMENTS	1997	550	46	10	46		550	55
56	SECURITY SYSTEM	1997	9,529	635	10	635		6,880	56
57	CARPET/TILE FOR ALZ UNIT	1997	47,225	1,219	10	1,219		47,225	57
58	DRIVEWAY /PARKING LOT	1997	13,637	909	15	909		9,696	58
59	COURTYARD IMPROVEMENTS	1997	58,578	5,150	VARIOUS	5,150		54,354	59
60	WINDOW TREATMENTS	1997	684	25	10	25		684	60
61	CORRIDOR FIXTURES	1998	1,008		5			1,008	61
62	ARCHITECT	1998	718	18	40	18		180	62
63	SHOWER GRAB BARS	1998	592	15	40	15		150	63
64	DOOR ALARM	1998	4,066	102	40	102		981	64
65	LANDSCAPING	1998	750	29	10	29		750	65
66	PARKING LOT	1998	64,900	4,327	15	4,327		40,752	66
67	RISER/SEAL TREATMENT PLANT	2002	1,090	73	15	73		438	67
68	FIREWALL/DOOR INSTALLATION	2003	7,046	141	50	141		564	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,692,700	\$ 128,605		\$ 128,605	\$	\$ 2,342,377	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	HANDRAILS	2003	\$ 1,175	\$ 59	20	\$ 59	\$	\$ 236	37
38	EXIT LIGHTING	2003	3,290	165	20	165		660	38
39	SPRINKLER SYSTEM	2003	104,729	2,095	50	2,095		9,078	39
40	CARPETING	2004	30,877	643	20	643		2,572	40
41	CHAIN LINK FENCE	2004	792	79	10	79		270	41
42	SIGN	2005	8,900	593	15	593		1,433	42
43	WATER SOFTNER	2005	9,667	967	10	967		2,256	43
44	FLOORING	2005	655	44	15	44		95	44
45	CEILING TILE FOR KITCHEN	2005	948	47	20	47		102	45
46	FLOORING IN 4 ROOMS	2005	3,770	189	20	189		378	46
47	FLOORING IN SHOWERS	2006	7,400	493	15	493		904	47
48	LOFT IN GARAGE	2006	580	15	40	15		25	48
49	FLOORING IN CLOSETS	2006	1,000	67	15	67		106	49
50	COUNTERTOP & STORAGE BOXES	2007	1,197	67	15	67		67	50
51	HVAC SYSTEM	2007	121,775	1,015	20	1,015		1,015	51
52	FLOORING-FAITH PLACE	2007	52,500	1,750	15	1,750		1,750	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)		\$ 4,761,141	\$ 121,472		\$ 121,472	\$	\$ 2,146,986	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 1,150,988	\$ 66,117	\$ 66,117	\$	VARIOUS	\$ 506,546	71
72	Current Year Purchases	66,565	4,474	4,474		10	4,474	72
73	Fully Depreciated Assets	412,554				VARIOUS	412,554	73
74								74
75	TOTALS	\$ 1,630,107	\$ 70,591	\$ 70,591	\$		\$ 923,574	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	RES TRANSPORTATION	1993 FORD VAN	1993	\$ 39,000	\$	\$	\$		\$ 39,000	76
77	RES TRANSPORTATION	1993 FORD VAN	2003	9,500	950	950		10	4,117	77
78										78
79										79
80	TOTALS			\$ 48,500	\$ 950	\$ 950	\$		\$ 43,117	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)		\$ 6,380,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 200,146	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 200,146	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)		\$ 3,309,068	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	LAND DONATED TO BE USED	\$ 35,540	\$	\$	86
87	FOR EXPANSION				87
88					88
89					89
90					90
91	TOTALS	\$ 35,540	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	ARCHITECT FEES	\$ 3,000	92
93			93
94			94
95		\$ 3,000	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: _____

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

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	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" 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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>46</u></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		50		50
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		3,111		3,111
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		200		200
9	TOTALS	\$	\$ 3,361	\$	\$ 3,361
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,361		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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		hrs	\$	1,257	\$ 82,260	\$ 774	1,257	\$ 83,034	1
2	Licensed Speech and Language Development Therapist		hrs		29	2,199		29	2,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,885	126,436	466	1,885	126,902	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	3,171	\$ 210,895	\$ 1,240	3,171	\$ 212,135	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 PRAIRIEVIEW LUTHERAN HOME

0018044

Report Period Beginning: 1/1/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 325,347	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	639,443		3
4	Supply Inventory (priced at <u>COST</u>)	23,379		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,824		6
7	Other Prepaid Expenses	9,799		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM OTHER FUNDS</u>	75,021		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,091,813	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,655		13
14	Buildings, at Historical Cost	4,765,399		14
15	Leasehold Improvements, at Historical Cost	252,323		15
16	Equipment, at Historical Cost	1,318,045		16
17	Accumulated Depreciation (book methods)	(3,309,068)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,071,354	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,163,167	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 177,862	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,671		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,490		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,100		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>DEFERRED REV/BONDS</u>	464,892		36
37	<u>DUE TO OTHER FUNDS</u>	241,437		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,108,452	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	140,000		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)	\$ 140,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,248,452	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,914,715	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,163,167	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,799,343	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,799,343	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(38,486)	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)	\$ (38,486)	17
	B. Transfers (Itemize):		
18	FOUNDATION	153,858	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 153,858	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,914,715	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME# 0018044Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 5,756,897	1
2	Discounts and Allowances for all Levels	(505,636)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,251,261	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	206,420	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 206,420	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	24,956	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,956	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,606	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,606	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SIU/ADMIN FEE	34,086	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,086	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,522,329	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,709,824	31
32	Health Care	1,414,508	32
33	General Administration	1,140,849	33
B. Capital Expense			
34	Ownership	219,846	34
C. Ancillary Expense			
35	Special Cost Centers	25,418	35
36	Provider Participation Fee	50,370	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,560,815	40
41	Income before Income Taxes (line 30 minus line 40)**	(38,486)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (38,486)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **PRAIRIEVIEW LUTHERAN HOME**

0018044

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	2,968	3,296	\$ 95,368	\$ 28.93	1
2	Assistant Director of Nursing	3,519	4,024	103,482	25.72	2
3	Registered Nurses	13,664	15,119	314,590	20.81	3
4	Licensed Practical Nurses	20,856	22,457	418,274	18.63	4
5	CNAs & Orderlies	87,350	94,886	1,018,793	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,765	1,977	24,170	12.23	8
9	Activity Director	3,224	3,520	54,528	15.49	9
10	Activity Assistants	13,231	14,538	143,086	9.84	10
11	Social Service Workers	1,800	2,080	30,900	14.86	11
12	Dietician					12
13	Food Service Supervisor	1,800	1,960	32,030	16.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,696	37,395	309,162	8.27	15
16	Dishwashers					16
17	Maintenance Workers	4,862	5,463	91,490	16.75	17
18	Housekeepers	13,394	15,140	143,896	9.50	18
19	Laundry	7,657	8,315	70,388	8.47	19
20	Administrator	1,134	1,310	63,630	48.57	20
21	Assistant Administrator					21
22	Other Administrative	6,285	7,073	123,232	17.42	22
23	Office Manager					23
24	Clerical	7,772	8,312	90,592	10.90	24
25	Vocational Instruction	411	411	9,140	22.24	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	360	360	4,571	12.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	226,748	247,636	\$ 3,141,322 *	\$ 12.69	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	151	\$ 8,154	1-3	35
36	Medical Director	192	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	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	9	678	11-3	44
45	Social Service Consultant	3	271	12-3	45
46	Other(specify)				46
47	CONSULTANT RESTORATIVE	1	28	10A-3	47
48					48
49	TOTAL (lines 35 - 48)	368	\$ 14,231		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	42	\$ 1,702	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	42	\$ 1,702		53

SEE ACCOUNTANTS' COMPILATION REPORT

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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 PRAIRIEVIEW LUTHERAN HOME

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN \$4458
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,159 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
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. \$ 10,477 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FOX CPA GROUP, LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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.

SEE ACCOUNTANTS' COMPILATION REPORT