



Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189 Report Period Beginning: 1/1/2008 Ending: 9/8/2008

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	47	Skilled (SNF)	47	11,844	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	47	TOTALS	47	11,844	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other			
8	SNF	4,392	2,331	182	6,905	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	4,392	2,331	182	6,905	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.30%

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 04/30/2001

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

YES

Date 04/30/2001

NO

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

YES

NO

If YES, enter number of beds certified 9 and days of care provided 182

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Prairie City Rehab & Health Care # 0049189 Report Period Beginning: 1/1/2008 Ending: 9/8/2008

**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
	<b>A. General Services</b>										
1	Dietary	63,238	4,199		67,437		67,437		67,437		1
2	Food Purchase		34,816		34,816		34,816	(131)	34,685		2
3	Housekeeping	38,542	5,653		44,195		44,195		44,195		3
4	Laundry	10,313	3,111		13,424		13,424		13,424		4
5	Heat and Other Utilities			28,800	28,800		28,800		28,800		5
6	Maintenance	6,687	2,277	13,098	22,062		22,062		22,062		6
7	Other (specify):* <u>Home Off. Ben. All.</u>										7
8	<b>TOTAL General Services</b>	<b>118,780</b>	<b>50,056</b>	<b>41,898</b>	<b>210,734</b>		<b>210,734</b>	<b>(131)</b>	<b>210,603</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	269,933	12,068	1,268	283,269		283,269	(94)	283,175		10
10a	Therapy			26,668	26,668		26,668		26,668		10a
11	Activities	12,614	252	262	13,128		13,128		13,128		11
12	Social Services	18,200			18,200		18,200		18,200		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	<b>TOTAL Health Care and Programs</b>	<b>300,747</b>	<b>12,320</b>	<b>28,198</b>	<b>341,265</b>		<b>341,265</b>	<b>(94)</b>	<b>341,171</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	33,333		29,600	62,933		62,933		62,933		17
18	Directors Fees										18
19	Professional Services			2,150	2,150		2,150		2,150		19
20	Dues, Fees, Subscriptions & Promotions			2,627	2,627		2,627		2,627		20
21	Clerical & General Office Expenses	13,867	2,197	3,582	19,646		19,646	(167)	19,479		21
22	Employee Benefits & Payroll Taxes			71,864	71,864		71,864		71,864		22
23	Inservice Training & Education			88	88		88		88		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			2,394	2,394		2,394		2,394		25
26	Insurance-Prop.Liab.Malpractice			4,744	4,744		4,744		4,744		26
27	Other (specify):* <u>Home Off. Ben. All.</u>										27
28	<b>TOTAL General Administration</b>	<b>47,200</b>	<b>2,197</b>	<b>117,049</b>	<b>166,446</b>		<b>166,446</b>	<b>(167)</b>	<b>166,279</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>466,727</b>	<b>64,573</b>	<b>187,145</b>	<b>718,445</b>		<b>718,445</b>	<b>(392)</b>	<b>718,053</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Prairie City Rehab &amp; Health Care

#0049189

Report Period Beginning:

1/1/2008

Ending:

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## 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	
	<b>D. Ownership</b>											
30	Depreciation			544	544		544	6,074	6,618			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,449	21,449		21,449	(4)	21,445			32
33	Real Estate Taxes			17,600	17,600		17,600		17,600			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,409	1,409		1,409		1,409			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			41,002	41,002		41,002	6,070	47,072			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,221		3,221		3,221		3,221			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			17,202	17,202		17,202		17,202			42
43	Other (specify):* Non-allowable Cost		8	7,427	7,435		7,435	(7,435)				43
44	<b>TOTAL Special Cost Centers</b>		3,229	24,629	27,858		27,858	(7,435)	20,423			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	466,727	67,802	252,776	787,305		787,305	(1,757)	785,548			45

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



## Prairie City Rehab &amp; Health Care

ID# 0049189

Report Period Beginning: 1/1/2008

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (208)	43	1
2	X-Rays-Part A	(223)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(94)	10	3
4	Offset Miscellaneous Food Revenue	(131)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(167)	21	5
6	Resident Flowers	(8)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(831)		49

**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
Eddie Fransiscovich	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	N/A						1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Prairie City Rehab &amp; Health Care

# 0049189

Report Period Beginning:

1/1/2008

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9/8/2008

## 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	Eddie Fransicovich	Administrator	Administrative	100.00	0	40	100.00	Salary	\$ 33,333	L17, C1	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	\$ 33,333		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 City Rehab & Health Care

# 0049189 Report Period Beginning: 1/1/2008

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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 &amp; ID Number

Prairie City Rehab &amp; Health Care

# 0049189

Report Period Beginning:

1/1/2008

Ending:

9/8/2008

## 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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Ipava Bank		X	Mortgage	\$2,677.97	4/21/06	\$ 320,000	\$ 298,764	4/21/16	0.0800	\$ 21,449	1						
2	Eddie Fransiscovich	X		Long-Term Working Capital		VAR	481,182	481,182	Demand	None		2						
3	James Petersen	X		Long-Term Working Capital		VAR	10,000	10,000	Demand	None		3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$2,677.97		\$ 811,182	\$ 789,946			\$ 21,449	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11									Interest Income Offset			(4)						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (4)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 811,182	\$ 789,946			\$ 21,445	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 (continued)**

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2007 report.		\$	<b>26,000</b>	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.)	2007	\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(26,000)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>43,600</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>17,600</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>3,994</b>	8
	2004	<b>4,114</b>	9
	2005	<b>4,216</b>	10
	2006	<b>4,359</b>	11
	2007		12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Prairie City Rehab & Health Care COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0049189

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 2007 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 2007.

(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>N/A</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>
<b>TOTALS</b>		\$ <u></u>	\$ <u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock 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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>216,058</u>	<u>2001</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>216,058</b>		<b>\$ 9,000</b>	<b>3</b>

Facility Name & ID Number Prairie City Rehab & Health Care# 0049189

Report Period Beginning:

1/1/2008

Ending:

9/8/2008**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	47	2001	1970	\$ 53,000	\$	39	\$ 906	\$ 906	\$ 9,739	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Sewer hook-Up		2001	2,894		39	49	49	531	9
10	Architectural Design		2001	2,903		39	50	50	497	10
11	Roofing Materials		2002	878		39	15	15	141	11
12	2 New Bathrooms		2002	13,854		39	237	237	2,220	12
13	Install Grease Trap		2002	1,318		39	23	23	212	13
14	Floor Tiles & Carpet		2002	7,578		39	129	129	1,197	14
15	Sprinkler Heads		2002	2,649		39	45	45	419	15
16	Architectural Design		2002	10,792		39	185	185	1,707	16
17	Upgrade Shower and Bath		2002	3,370		39	57	57	525	17
18	Architectural Design		2002	500		39	9	9	76	18
19	Lighting Fixtures and Wallpaper		2002	4,097		39	70	70	613	19
20	Ceiling Tiles		2002	2,152		39	37	37	345	20
21	Hardwood Items		2002	1,771		39	30	30	283	21
22	Building Materials		2002	728		39	13	13	114	22
23	Upgrade Drainage System		2002	1,067		39	18	18	166	23
24	Painting		2003	4,320		15	192	192	1,584	24
25	Heater Repair		2003	2,300		15	102	102	843	25
26	Firewall Installation		2005	24,119		39	413	413	1,702	26
27	Sidewalk Repair		2008	1,850		15	82	82	82	27
28	Alarm System		2008	725		7	69	69	69	28
29										29
30										30
31										31
32										32
33	Building Improvements Booked				151			(151)		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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 142,865	\$ 151		\$ 2,731	\$ 2,580	\$ 23,065	70

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

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

Report Period Beginning:

1/1/2008

Ending:

9/8/2008

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	\$ 87,873	\$ 393	\$ 3,625	\$ 3,232	5-7 years	\$ 82,551	71
72	Current Year Purchases	4,129	262	262			262	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 92,002	\$ 655	\$ 3,887	\$ 3,232		\$ 82,813	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 243,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 806	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,618	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,812	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 105,879	85

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

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

G. Construction-in-Progress

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

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

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

**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: \$ 1,409 Description: See Attached 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			<u>N/A</u>		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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 City Rehab & Health Care**

**0049189**

**Period Beginning 1/1/2008**

**Period End 9/8/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	1,409
		<hr/>
		1,409
		<hr/>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	709	\$ 10,637	\$	709	\$ 10,637	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,069	16,031		1,069	16,031	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				3,221		3,221	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	1,778	\$ 26,668	\$ 3,221	1,778	\$ 29,889	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 City Rehab & Health Care**

# **0049189**

Report Period Beginning: **1/1/2008**

Ending:

**9/8/2008**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **9/8/2008**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (76,927)	\$ (76,927)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	126,705	126,705	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	610	610	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 50,388	\$ 50,388	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000	9,000	13
14	Buildings, at Historical Cost	53,000	53,000	14
15	Leasehold Improvements, at Historical Cost	89,865	89,865	15
16	Equipment, at Historical Cost	92,002	92,002	16
17	Accumulated Depreciation (book methods)	(105,879)	(105,879)	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): <u>A/R-Prior Owner</u>	77,666	77,666	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 215,654	\$ 215,654	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 266,042	\$ 266,042	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 171,415	\$ 171,415	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,671	23,671	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,960	1,960	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,600	43,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	5,184	5,184	36
37	<u>Due to Manager</u>	47,794	47,794	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 293,624	\$ 293,624	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	10,000	10,000	39
40	Mortgage Payable	779,946	779,946	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 789,946	\$ 789,946	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,083,570	\$ 1,083,570	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (817,528)	\$ (817,528)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 266,042	\$ 266,042	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(692,547)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(692,547)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(124,981)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(124,981)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(817,528)</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 630,776	1
2	Discounts and Allowances for all Levels	11,862	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 642,638	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,023	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 13,023	8
	<b>C. Other Operating Revenue</b>		
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	131	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	311	20
21	Other Medical Services	907	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,398	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	261	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 261	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 662,324	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	210,734	31
32	Health Care	341,265	32
33	General Administration	166,446	33
	<b>B. Capital Expense</b>		
34	Ownership	41,002	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	10,656	35
36	Provider Participation Fee	17,202	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 787,305	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(124,981)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (124,981)	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. Facility is part of larger entity.

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

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

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

Report Period Beginning: 1/1/2008

Ending: 9/8/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,187	1,187	\$ 28,326	\$ 23.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,772	2,772	47,482	17.13	3
4	Licensed Practical Nurses	3,377	3,419	55,243	16.16	4
5	CNAs & Orderlies	13,253	13,457	116,942	8.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,295	1,295	12,614	9.74	9
10	Activity Assistants					10
11	Social Service Workers	1394	1,394	18,200	13.06	11
12	Dietician					12
13	Food Service Supervisor	1,373	1,373	15,050	10.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,951	6,160	48,188	7.82	15
16	Dishwashers					16
17	Maintenance Workers	575	635	6,687	10.53	17
18	Housekeepers	4,838	5,017	38,542	7.68	18
19	Laundry	1,187	1,307	10,313	7.89	19
20	Administrator	1,394	1,394	33,333	23.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,376	1,385	13,867	10.01	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)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,373	1,373	21,940	15.98	33
34	TOTAL (lines 1 - 33)	41,345	42,168	\$ 466,727 *	\$ 11.07	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	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	Monthly	400	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)	\$	400	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	
Eddie Fransiscovich	Administrator	0	\$ 33,333	Workers' Compensation Insurance	\$ 2,379	IDPH License Fee	\$	
				Unemployment Compensation Insurance	13,718	Advertising: Employee Recruitment	1,647	
				FICA Taxes	34,139	Health Care Worker Background Check		
				Employee Health Insurance	21,628	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	530	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits		
						Miscellaneous Dues & Subscriptions		
TOTAL (agree to Schedule V, line 17, col. 1)						IHCA Dues	450	
(List each licensed administrator separately.)			\$ 33,333					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			Less: Public Relations Expense ( )	
Description			Amount			Non-allowable advertising ( )		
Management Fees			\$ 29,600			Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 29,600		\$ 71,864	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
E-Health Data Solutions	Computer Services		\$ 1,350				Out-of-State Travel	\$
Mediacom	Computer Services		800					
							In-State Travel	
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense ( )	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,150				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Prairie City Rehab & Health Care# 0049189Report Period Beginning: 1/1/2008Ending: 9/8/2008**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. 450 -IHCA
- (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? No
- (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. \$ 3,240 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? N/A  
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. \$ 17,202  
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. \$ 131
- (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. \$ No  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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