



Facility Name & ID Number Prairie Rose Health Care Center

# 0045245 Report Period Beginning: 1/1/2008 Ending: 12/31/08

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	105	Skilled (SNF)	105	38,430	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	105	TOTALS	105	38,430	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	15,546	3,774	2,148	21,468	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,546	3,774	2,148	21,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.86%

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 3/1/1995

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

YES

Date 3/1/1995

NO

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

YES

NO

If YES, enter number of beds certified 105 and days of care provided 2,148

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2008 Ending: 12/31/08

**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	201,856	18,680	5,727	226,263		226,263		226,263		1
2	Food Purchase		133,476		133,476		133,476	(7,251)	126,225		2
3	Housekeeping	116,630	14,097		130,727		130,727		130,727		3
4	Laundry	17,334	16,861		34,195		34,195		34,195		4
5	Heat and Other Utilities			118,410	118,410		118,410		118,410		5
6	Maintenance	23,187	10,021	32,449	65,657		65,657		65,657		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	359,007	193,135	156,586	708,728		708,728	(7,251)	701,477		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	1,066,802	139,001	2,291	1,208,094		1,208,094	(1,861)	1,206,233		10
10a	Therapy	174,155		196,801	370,956		370,956		370,956		10a
11	Activities	7,266	780	1,696	9,742		9,742		9,742		11
12	Social Services	31,018			31,018		31,018		31,018		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,279,241	139,781	222,788	1,641,810		1,641,810	(1,861)	1,639,949		16
	<b>C. General Administration</b>										
17	Administrative	110,960		191,500	302,460		302,460		302,460		17
18	Directors Fees										18
19	Professional Services			18,301	18,301		18,301		18,301		19
20	Dues, Fees, Subscriptions & Promotions			6,971	6,971		6,971		6,971		20
21	Clerical & General Office Expenses	64,415	5,446	22,350	92,211		92,211	(749)	91,462		21
22	Employee Benefits & Payroll Taxes			303,884	303,884		303,884		303,884		22
23	Inservice Training & Education			588	588		588		588		23
24	Travel and Seminar			347	347		347		347		24
25	Other Admin. Staff Transportation			11,093	11,093		11,093		11,093		25
26	Insurance-Prop.Liab.Malpractice			38,308	38,308		38,308		38,308		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	175,375	5,446	593,342	774,163		774,163	(749)	773,414		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,813,623	338,362	972,716	3,124,701		3,124,701	(9,861)	3,114,840		29

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

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

Facility Name &amp; ID Number

Prairie Rose Health Care Center

#0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

## 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			163,123	163,123		163,123	(16,694)	146,429			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			220,264	220,264		220,264	(1,933)	218,331			32
33	Real Estate Taxes			43	43		43	(43)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,762	15,762		15,762		15,762			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			399,192	399,192		399,192	(18,670)	380,522			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,418		74,418		74,418		74,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,326	56,326		56,326		56,326			42
43	Other (specify):* Non-allowable Cost	31,282	789	126,876	158,947		158,947	(158,947)				43
44	<b>TOTAL Special Cost Centers</b>	31,282	75,207	183,202	289,691		289,691	(158,947)	130,744			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,844,905	413,569	1,555,110	3,813,584		3,813,584	(187,478)	3,626,106			45

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,251)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,004)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,694)	30		9
10	Interest and Other Investment Income	(1,933)	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	(6,049)	43		18
19	Entertainment				19
20	Contributions	(220)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,271)	43		24
25	Fund Raising, Advertising and Promotional	(5,519)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(41,537)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (187,478)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (187,478)		37

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

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

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

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 1/1/2008

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,276)	43	1
2	X-Rays-Part A	(2,607)	43	2
3	Resident Flower	(300)	43	3
4	Special Events	(419)	43	4
5	Miscellaneous Revenue Offset-Office Supplies	(749)	21	5
6	Miscellaneous Revenue Offset-Nursing Supplies	(1,861)	10	6
7	Disallowed Marketing Salaries	(31,282)	43	7
8	Disallowed R.E. Taxes	(43)	33	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>	(41,537)		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
SJL Health Systems, Inc.	100	South Shore Health Care, LLC	Gary, Indiana	None		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V							1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

**Prairie Rose Health Care Center**  
**0045245**

**Period Beginning** 1/1/2008

**Period End** 12/31/2008

**Schedule 6A-Board of Directors**

**President**

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

**Secretary**

Thomas Hammerton  
3400 W. Brenwick Drive  
Peoria, IL 61614

**Treasurer**

Brad Barkley  
830 W. Trailcreek Drive, Suite B  
Peoria, IL 61614

**Director at Large**

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

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

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

Facility Name &amp; ID Number

Prairie Rose Health Care Center

#

0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A									1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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

# **0045245**

Report Period Beginning:

**1/1/2008**

Ending: **12/31/08**

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Prairie Rose Health Care Center

# 0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

**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	AMI Capital, Inc.		X	Mortgage	\$21,167.65	12/01/02	\$ 3,580,869	\$ 3,340,030	11/01/35	0.0618	\$ 207,732	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$21,167.65		\$ 3,580,869	\$ 3,340,030			\$ 207,732	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11							Amortization of Bond Issuance Cost				12,532	11						
12							Interest Revenue Offset				(1,933)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 10,599	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,580,869	\$ 3,340,030			\$ 218,331	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 13,973      Line # 26

\* 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.

\$ **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** \$ **43** **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **43** **3**

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

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

\$ **5**

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

**Disallowed R.E. Taxes (43)**

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

\$ **6**

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

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>8</b>
	<b>2004</b>	<b>9</b>
	<b>2005</b>	<b>10</b>
	<b>2006</b>	<b>11</b>
	<b>2007</b>	<b>43</b>

**This entity is a not-for-profit and therefore does not get assessed taxes on its business assets**

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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 Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>11-25-21-401-010-00</u>	<u>Land</u>	\$ <u>43.30</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>43.30</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? X 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 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: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

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

Facility Name &amp; ID Number Prairie Rose Health Care Center

# 0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121	1995	1976	\$ 1,068,665	\$	30	\$ 35,622	\$ 35,622	\$ 457,150	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	1986 Additions		1986	970,363		30	32,345	32,345	714,293	9
10	1987 Additions		1987	110,922		29	3,825	3,825	80,059	10
11	1989 Additions		1989	2,219		10			2,219	11
12	1990 Additions		1990	4,295		30	143	143	4,127	12
13	1991 Additions		1991	134,283		7			134,283	13
14	1992 Additions		1992	17,130		7			17,130	14
15	1993 Additions		1993	24,239		7			24,239	15
16	1994 Additions		1994	10,559		7			10,559	16
17	1995 Additions		1995	14,617		15	974	974	13,086	17
18	1996 Additions		1996	305,057		12	12,715	12,715	305,057	18
19	1997 Additions		1997	23,542		10			23,542	19
20	Whirlpool Bath		1998	9,120		10			9,120	20
21	Lift, Bath Trolley		1998	3,850		10			3,850	21
22	Shower Room		1998	4,884		10	41	41	4,884	22
23	Entrance Doors		1998	2,358		20	118	118	1,209	23
24	Curtains		1998	6,102		5			6,102	24
25	Sidewalk & Pad		1999	1,484		15	99	99	948	25
26	Divide Receipts on Emergency Generator		1999	2,397		20	120	120	1,139	26
27	Med Room Cabinets and Counter Top		1999	2,008		20	100	100	904	27
28	Heat/Cool		2000	1,876		7			1,876	28
29	Door Alarms		2001	1,215		15	81	81	540	29
30	Dining Room, Living Room, Shower Remodel		2001	94,315		30	3,144	3,144	23,841	30
31	Wooded Doors		2001	1,900		15	127	127	898	31
32	Landscaping-Renovation Project		2001	1,174		10	117	117	1,019	32
33	Bituminous Parking Lot		2001	22,030		8	2,754	2,754	19,507	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.

Facility Name &amp; ID Number Prairie Rose Health Care Center

# 0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replace Plumbing Fixtures	2002	\$ 2,490	\$	20	\$ 125	\$ 125	\$ 872	37
38	Therapy Room Remodel	2002	5,617		20	281	281	1,826	38
39	Remodel Medication/Utility Rooms	2002	7,909		20	395	395	2,570	39
40	2 Heating/Cooling Roof Top Units	2002	11,300		10	1,130	1,130	7,251	40
41	Breakroom Remodel	2002	3,106		10	311	311	1,993	41
42	Exterior Window Covering	2002	7,650		7	1,093	1,093	6,921	42
43	Lights for Therapy Room	2002	805		10	81	81	491	43
44	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	11,206	44
45	Fire Supression System	2004	1,540		10	154	154	629	45
46	Antenna	2004	2,944		10	294	294	1,422	46
47	Sign	2004	1,200		10	120	120	480	47
48	Carpet	2005	1,281		5	256	256	982	48
49	Sidewalks	2006	8,735		10	874	874	2,215	49
50	Duct Work	2007	5,120		15	342	342	513	50
51	Water Heater	2007	5,378		10	538	538	807	51
52	Sidewalks	2007	8,976		15	598	598	897	52
53	Water Heater & Duct Work	2008	4,850		10	243	243	243	53
54	Air Conditioner-Rooftop	2008	9,120		10	456	456	456	54
55	Plumbing Repair	2008	3,442		10	344	344	344	55
56	Ceramic Tile Replacement	2008	9,996		20	250	250	250	56
57	Vinyl Tile Replacement	2008	4,495		20	225	225	225	57
58	Sidwalk Marquee	2008	4,985		10	249	249	249	58
59	Generator Repair	2008	2,562		10	128	128	128	59
60	Specialized Dementia Unit	2008	114,503		20	2,863	2,863	2,863	60
61									61
62	Building Booked			35,622			(35,622)		62
63	Building Improvements Booked			76,406			(76,406)		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,105,450	\$ 112,028		\$ 105,517	\$ (6,511)	\$ 1,907,414	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 928,933	\$ 49,483	\$ 39,053	\$ (10,430)	3-15 yr.	\$ 681,572	71
72	Current Year Purchases	37,189	1,612	1,859	247	10	1,859	72
73	Fully Depreciated Assets	58,744					58,744	73
74								74
75	TOTALS	\$ 1,024,866	\$ 51,095	\$ 40,912	\$ (10,183)		\$ 742,175	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1994	\$ 27,905	\$	\$	\$	5	\$ 27,905	76
77										77
78										78
79										79
80	TOTALS			\$ 27,905	\$	\$	\$		\$ 27,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,171,721	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,429	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,694)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,677,494	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?  YES  NO

If NO, see instructions.

		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: \$ 15,762 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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /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 Rose**

**Period Beginning**                      **1/1/2008**

**Period End**                              **12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	11,623
Dishwasher		708
Copier		3,431
Total		<u>15,762</u>

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

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

<p><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	\$	5,443	\$ 81,652	\$	5,443	\$ 81,652	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		526	7,889		526	7,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,151	107,260		7,151	107,260	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				74,418		74,418	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10A(1)	9230 hours	174,155				9,230	174,155	13
14	<b>TOTAL</b>			\$ 174,155	13,120	\$ 196,801	\$ 74,418	22,350	\$ 445,374	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 &amp; ID Number Prairie Rose Health Care Center

# 0045245

Report Period Beginning: 1/1/2008

Ending: 12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ (56,852)	\$ (56,852)	1
2	Cash-Patient Deposits	39,460	39,460	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000 )	638,653	638,653	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,300	28,300	6
7	Other Prepaid Expenses	63,727	63,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 713,288	\$ 713,288	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,415	13,500	13
14	Buildings, at Historical Cost	2,842,209	1,068,665	14
15	Leasehold Improvements, at Historical Cost	155,234	2,036,785	15
16	Equipment, at Historical Cost	1,119,864	1,052,771	16
17	Accumulated Depreciation (book methods)	(2,368,353)	(2,677,494)	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):	337,371	337,371	22
23	Other(specify): See Schedule 17A	526,425	526,425	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,667,165	\$ 2,358,023	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,380,453	\$ 3,071,311	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 613,893	\$ 613,893	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,677	131,677	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,201	17,201	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Payroll Withholdings	33,737	33,737	36
37	Due to Tutores	458,743	458,743	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,255,251	\$ 1,255,251	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,340,030	3,340,030	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	A/P-IDPA Integrity Audit	32,689	32,689	43
44	Due to Manager	351,000	351,000	44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 3,723,719	\$ 3,723,719	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,978,970	\$ 4,978,970	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,598,517)	\$ (1,907,659)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,380,453	\$ 3,071,311	48

\*(See instructions.)

**Prairie Rose Health Care Center  
0045245**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 17A**

**XV. Balance Sheet**

**Long Term Assets**

**Line 23 - Other Long-Term Assets**

	Operating	After Consolidation
Replacement & Reserve Fund	254,238	254,238
Project Fund-Insurance	8,803	8,803
Completion Repair	239,175	239,175
MIP Reserve	24,209	24,209
<b>Total Line 23 Other Long-Term Assets</b>	<b>526,425</b>	<b>526,425</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,069,166)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</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>(1,069,165)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(529,352)</b>	<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>(529,352)</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>(1,598,517)</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	\$ 2,714,552	1
2	Discounts and Allowances for all Levels	(74,609)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,639,943	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,919	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 328,919	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	7,251	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	170,331	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	87,286	20
21	Other Medical Services	45,959	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 310,827	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,933	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,933	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	2,610	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,610	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,284,232	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	708,728	31
32	Health Care	1,641,810	32
33	General Administration	774,163	33
	<b>B. Capital Expense</b>		
34	Ownership	399,192	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	233,365	35
36	Provider Participation Fee	56,326	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,813,584	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(529,352)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (529,352)	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 Rose Health Care Center

# 0045245

Report Period Beginning:

1/1/2008

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 50,750	\$ 24.40	1
2	Assistant Director of Nursing	2,080	2,080	39,000	18.75	2
3	Registered Nurses	4,958	5,331	108,241	20.30	3
4	Licensed Practical Nurses	19,093	20,356	341,373	16.77	4
5	CNAs & Orderlies	48,669	50,899	496,033	9.75	5
6	CNA Trainees					6
7	Licensed Therapist	10,790	11,232	205,437	18.29	7
8	Rehab/Therapy Aides					8
9	Activity Director	935	1,015	5,783	5.70	9
10	Activity Assistants	252	288	1,483	5.15	10
11	Social Service Workers	1,889	2,097	31,018	14.79	11
12	Dietician					12
13	Food Service Supervisor	6,240	6,240	99,475	15.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,655	12,296	102,381	8.33	15
16	Dishwashers					16
17	Maintenance Workers	1,833	1,873	23,187	12.38	17
18	Housekeepers	11,364	12,006	116,630	9.71	18
19	Laundry	2,704	2,861	17,334	6.06	19
20	Administrator	4,160	4,160	110,960	26.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,324	4,340	64,415	14.84	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 C: <u>Care Plan Coord.</u>	1,979	1,979	31,405	15.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,005	141,133	\$ 1,844,905 *	\$ 13.07	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	100 hrs.	\$ 5,727	1(3)	35
36	Medical Director	Monthly	22,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	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)		\$ 28,927		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laura Morrell	Administrator	0	\$ 40,960	Workers' Compensation Insurance	\$ 75,224	IDPH License Fee	\$ 1,990	
Margaret West	Administrator	0	70,000	Unemployment Compensation Insurance	4,668	Advertising: Employee Recruitment	1,466	
				FICA Taxes	134,407	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	86,002	Patient Background Checks	66	
				Employee Meals		Miscellaneous Dues & Subscriptions	350	
				Illinois Municipal Retirement Fund (IMRF)*		M.E.S. Dues	2,500	
				Employee Relations	386	Miscellaneous Licenses & Permits	5	
				Employee Retirement	3,172			
				Employee Life Insurance	25			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,960			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Management Fees			\$ 191,500					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 191,500	TOTAL (agree to Schedule V, line 22, col.8)	\$ 303,884	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,971	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ginoli & Company	Accounting Services		\$ 12,819				Out-of-State Travel	\$
Consolidated Communications	Computer Services		473					
Illinois Secretary of State	Legal Services		5				In-State Travel	
LTC Solutions	Computer Services		1,600	N/A				
AT & T	Computer Services		335					
E-Health Data Solutions	Computer Services		3,015				Seminar Expense	347
Wisconsin Physicians Service	Computer Services		54					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,301	TOTAL		\$	Entertainment Expense	( )

\* Attach copy of IMRF notifications

\*\*See instructions.

**Prairie Rose Health Care Center**

**0045245**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>
Laura Morrell	Administrator	0	40,960
Margaret West	Administrator	0	70,000
	<b>Total</b>		<u>110,960</u>



Facility Name & ID Number Prairie Rose Health Care Center# 0045245Report Period Beginning: 1/1/2008Ending: 12/31/08**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 8,157 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. \$ 56,326  
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. \$ 7,251
- (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? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees