



Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

# 0042671 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,084</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>19,032</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>46,116</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,325</u>	<u>3,325</u>	8
9	SNF/PED					9
10	ICF	<u>22,037</u>	<u>3,815</u>		<u>25,852</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,037</u>	<u>3,815</u>	<u>3,325</u>	<u>29,177</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.27%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 05/01/97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/97 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 53 and days of care provided 3,325

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL  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 VILLAGE HEALTHCARE CENT** # **0042671** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

**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	142,977	16,036	5,415	164,428		164,428		164,428		1
2	Food Purchase		171,217		171,217	(18,995)	152,222	(772)	151,450		2
3	Housekeeping	99,108	45,687		144,795		144,795		144,795		3
4	Laundry	55,157	17,389		72,546		72,546		72,546		4
5	Heat and Other Utilities			123,650	123,650		123,650	58	123,708		5
6	Maintenance	47,432	35,178	35,574	118,184		118,184	9,867	128,051		6
7	Other (specify):*			11,294	11,294		11,294	24	11,318		7
8	<b>TOTAL General Services</b>	<b>344,674</b>	<b>285,507</b>	<b>175,933</b>	<b>806,114</b>	<b>(18,995)</b>	<b>787,119</b>	<b>9,177</b>	<b>796,296</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	931,361	59,714	10,439	1,001,514		1,001,514	22,104	1,023,618		10
10a	Therapy	66,005	22,396	52,692	141,093		141,093	3,636	144,729		10a
11	Activities	43,632	6,013	7,769	57,414		57,414		57,414		11
12	Social Services	28,281		4,956	33,237		33,237		33,237		12
13	CNA Training										13
14	Program Transportation			1,275	1,275		1,275		1,275		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,069,279</b>	<b>88,123</b>	<b>83,131</b>	<b>1,240,533</b>		<b>1,240,533</b>	<b>25,740</b>	<b>1,266,273</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	65,645		60,000	125,645		125,645	11,389	137,034		17
18	Directors Fees										18
19	Professional Services			230,300	230,300		230,300	(154,385)	75,915		19
20	Dues, Fees, Subscriptions & Promotions			42,165	42,165		42,165	(27,901)	14,264		20
21	Clerical & General Office Expenses	42,064	15,294	133,869	191,227		191,227	(49,341)	141,886		21
22	Employee Benefits & Payroll Taxes			237,321	237,321	18,995	256,316		256,316		22
23	Inservice Training & Education			9,163	9,163		9,163	1,300	10,463		23
24	Travel and Seminar			715	715		715	48	763		24
25	Other Admin. Staff Transportation			2,963	2,963		2,963	7,743	10,706		25
26	Insurance-Prop.Liab.Malpractice			114,583	114,583		114,583	1,494	116,077		26
27	Other (specify):* <b>MARKETING</b>	19,891			19,891		19,891	13,834	33,725		27
28	<b>TOTAL General Administration</b>	<b>127,600</b>	<b>15,294</b>	<b>831,079</b>	<b>973,973</b>	<b>18,995</b>	<b>992,968</b>	<b>(195,819)</b>	<b>797,149</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,541,553</b>	<b>388,924</b>	<b>1,090,143</b>	<b>3,020,620</b>		<b>3,020,620</b>	<b>(160,902)</b>	<b>2,859,718</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.



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,275
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	60,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	37,224
	ADMINISTRATIVE CONSULTANTS XIX C	150,000
	PROFESSIONAL FEES XIX C	43,076
		0
		230,300
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	30,375
	EMPLOYEE WANT ADS XIX F	8,340
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	2,850
	LICENSES & PERMITS XIX F	600
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		42,165
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	296
	EQUIPMENT REPAIR & MAINTENANCE	7,809
	OUTSIDE CLERICAL SERVICES	96,000
	PENALTIES / OVERDRAFT CHARGES VI 18	16,436
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	98
	TELEPHONE	9,837
	MESSENGER SERVICE	3,393
		0
		133,869

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	115,577
	UNEMPLOYMENT COMPENSATION XIX D	30,200
	WORKERS COMPENSATION INSURANC XIX D	47,087
	HOSPITALIZATION INSURANCE XIX D	40,900
	EMPLOYEE BENEFITS - OTHER XIX D	889
	EMPLOYEE PHYSICAL EXAMS XIX D	2,668
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		237,321
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	9,163
		9,163
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	715
		715
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,963
		2,963
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	96,440
	INSURANCE EXPENSES	18,143
		114,583
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,090,143

**PRAIRIE VILLAGE HEALTHCARE CENTER  
SCHEDULES  
12/31/2008**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	171,217
LESS SALES TAX	(772)
NET FOOD	<u>170,445</u>
TOTAL PATIENT CENSUS	29,177
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	87,531
ADD # EMPLOYEE MEALS/DAY	<u>30</u>
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	10,980
PATIENT MEALS	87,531
ADD EMPLOYEE MEALS	<u>10,980</u>
TOTAL MEALS/YEAR	98,511
NET FOOD	170,445
DIVIDE TOTAL MEALS/YEAR	<u>98,511</u>
COST PER MEAL	1.73
TIME EMPLOYEE MEALS	<u>10,980</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>18,995</u>
	=====

**STAFF TRANSPORTATION  
PAGE 3 LINE 25 COLUMN 3 OTHER**

PAM ROONEY-BROWN	1,962
DIANNA BLACKKETTER	27
KARLA CURRIE	101
DEBBIE WEBB	163
PAM STEGE	125
TRISTA NAVE	112
CPM REIMB	473
TOTAL	<u>2,963</u>
	=====
GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING AND ACTIVITIES	

**PROFESSIONAL FEES  
PAGE 21 SCHEDULE XIX PART C**

CAREPLUS MGT	DATA PROCESSING	23,448
ACHIEVE HEALTHCARE	DATA PROCESSING	3,203
AMERICAN DATA	DATA PROCESSING	4,063
NATIONAL DATA CARE	DATA PROCESSING	2,079
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	3,600
ADAPTASOFT	DATA PROCESSING	403
EMDEON	DATA PROCESSING	428
CAREPLUS MGT	ADMINISTRATIVE CONSULTANT	150,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	24,100
MEYER MAGENCE	LEGAL	4,525
EDDIE CARPENTER	LEGAL	1,651
K. BROWNING MD	LEGAL COST	1,575
R.DOLAN RN	LEGAL COST	3,208
HONKAMP KREUGER	WOTC PROGRAM CONSULTANT	925
PERSONNEL PLANNER	UC CONSULTANT	2,292
RICHARD PEELO	MEDICARE COST REPORT	4,800
<b>TOTAL PROFESSIONAL FEES</b>		<b>230,300</b>
		=====

**EQUIPMENT RENTAL EXPENSE  
PAGE 14 SCHEDULE XII PART B LINES 15**

MEMORIAL HOME SERVICE	NURSING EQUIPMENT	84
QUALITY WATER SERVICE	PLANT EQUIPMENT	1,416
CENTRAL RENTAL	PLANT EQUIPMENT	902
FLYNN SALES & SERVICE	WASHER/DRYER	8,125
GE CAPITAL	COPIER	8,096
STORAGE	STORAGE SHED	541
<b>TOTAL EQUIPMENT RENTAL EXPENSE</b>		<b>19,164</b>
		=====

**EDUCATION AND SEMINARS  
PAGE 3 LINE 23 COLUMN 3 OTHER**

DATE	SPONSOR OF SEMINAR	SEMINAR PURPOSE	EMPLOYEE	LOC	COST
JAN	HCPRO	RELEASES NEW F-TAGS AND SURVEYOR GUIDANCE			209
JAN	CENTRAL PRAIRIE AMERICAN RED CROSS	CPR TEACHING MATERIAL		IL	350
JAN	IL HEALTH CARE ASSC	BE PREPARED FOR MDS MEDICAID AUDITS	KELLY ROTHERING	IL	400
			PAM ROONEY-BROWN		
FEB	ELDERCARE COMMUNICATION	DIGNITY			142
FEB	IL HEALTH CARE ASSC	MDS RAC-CT CERTIFICATION	KELLY ROTHERING	IL	450
FEB	MORGAN COUNTY HEALTH DEPT	FOOD SERVICE SANITATION MANAGER CERTIFICATION	VIRGINIA RIDDER	IL	85
MAR	MEDS-PDN	WOUND CARE WISDOM A PRACTICAL APPROACH TO A COMPLEX SUBJECT	DIANNA BLACKKETTER	IL	374
			PAM ROONEY-BROWN		
MAR	CROSS COUNTRY EDUCATION	PSYCHIATRIC DISORDERS IN THE AGING POPULATION: DIAGNOSIS AND TREATMENT OF THE OVERLOOKED PATIENT	DEBRA WEBB	IL	159
MAR	INDIANA DIETETIC ASSOCIATION	2006 INDIANA DIET MANUAL		IL	43
MAR	RAMIREZ CONSULTING GROUP	ACTIVITY DIRECTOR'S CERTIFICATION	LISA EDWARDS	IL	500
MAR	RAMIREZ CONSULTING GROUP	CEU ACTIVITY DIRECTOR'S CERTIFICATION	STACEY EDWARDS	IL	75
MAR	RAMIREZ CONSULTING GROUP	CEU ACTIVITY DIRECTOR'S CERTIFICATION	STACEY EDWARDS	IL	75
MAY	INR	REINVENTING MID LIFE: SLEEP AGING & OVEREATING	DIANNA BLACKKETTER	IL	162
			PAM ROONEY-BROWN		
MAY	IL HEALTH CARE ASSOC	ROAD TO EXCELLENCE: PAIN MANAGEMENT	KELLY ROTHERING	IL	380
			DIANNA BLACKKETTER		
MAY	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	MIRANDA TRANBARGER	IL	533
MAY	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	JOANNA WHITE	IL	533
JUN	LLCC	INTERPRETATION OF LAB TESTS	PAM ROONEY-BROWN	IL	200
			DIANNA BLACKKETTER		
JUL	ILLINOIS HEALTH CARE ASSOC	INTRO TO THE MDS	PAM ROONEY-BROWN	IL	400
			DIANNA BLACKKETTER		
SEP	INR	SEMINAR	DIANNA BLACKKETTER	IL	82
SEP	INR	SEMINAR	PAM ROONEY-BROWN	IL	82
SEP	AHCA	THE LONG TERM CARE SURVEY WITH QUARTERLY UPDATE	PAM ROONEY-BROWN	IL	163
SEP	CAREPLUS MANAGEMENT				215
OCT	ELDERCARE COMMUNICATIONS	PREVENT FALL/RELATED INJURY	PAM ROONEY-BROWN	IL	201
OCT	ELDERCARE COMMUNICATIONS	NUTRITION/FLUID DEFICIENCIES	PAM ROONEY-BROWN	IL	201
NOV	MORGAN COUNTY HEALTH	SANITATION CERTIFICATION	CREY HUFF	IL	85
NOV	MORGAN COUNTY HEALTH	SANITATION CERTIFICATION	DARRY BOOTH	IL	85
NOV	MORGAN COUNTY HEALTH	SANITATION CERTIFICATION	MARIAN HOLFING	IL	85
NOV	MORGAN COUNTY HEALTH	SANITATION CERTIFICATION	JUSTIN HENDERSON	IL	85
DEC	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	LEAH KOEHL HOFFEN	IL	610
DEC	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	TAYLOR BENNETT	IL	543
DEC	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	LORI KROEMELHEIN	IL	543
DEC	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASSISTANT	LISA EDMONDS	IL	543
DEC	LIPPINCOTT	NURSING PROCEDURES		IL	70
DEC	RAMIREZ CONSULTING GROUP	CEU ACTIVITY DIRECTOR'S CERTIFICATION	RICHARD BRIAN NOTTING	IL	500
					-----
		<b>TOTAL EDUCATION AND SEMINARS</b>			<b>9163</b>
					=====

Facility Name &amp; ID Number

PRAIRIE VILLAGE HEALTHCARE CENTER

#0042671

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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			14,086	14,086		14,086	67,200	81,286			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,607	9,607		9,607	179,171	188,778			32
33	Real Estate Taxes			15,825	15,825		15,825	4,878	20,703			33
34	Rent-Facility & Grounds			255,221	255,221		255,221	(255,221)				34
35	Rent-Equipment & Vehicles			27,378	27,378		27,378	5,394	32,772			35
36	Other (specify):* OFFICE RENT			12,600	12,600		12,600	(12,600)				36
37	<b>TOTAL Ownership</b>			334,717	334,717		334,717	(11,178)	323,539			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,828	157,904	273,732		273,732		273,732			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,174	69,174		69,174		69,174			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		115,828	227,078	342,906		342,906		342,906			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,541,553	504,752	1,651,938	3,698,243		3,698,243	(172,080)	3,526,163			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,513	30		9
10	Interest and Other Investment Income	(5,990)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(772)	2		13
14	Non-Care Related Interest	(6,795)	32		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	(16,436)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,375)	20		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 <u>SEE PG 5A</u>	(22,192)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (80,047)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(92,033)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (92,033)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (172,080)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0042671

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (19,891)	27	1
2	MAGENCE-LEGAL-PRIOR PERIOD	(650)	19	2
3	CARPENTER-LEGAL-COLLECTIONS	(1,651)	19	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
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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>	(22,192)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(772)	0	0	0	0	0	0	0	0	0	0	(772)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	58	0	0	0	0	0	0	0	0	0	58	5
6	Maintenance	0	9,867	0	0	0	0	0	0	0	0	0	9,867	6
7	Other (specify):*	0	24	0	0	0	0	0	0	0	0	0	24	7
8	<b>TOTAL General Services</b>	<b>(772)</b>	<b>9,949</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9,177</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,104	0	0	0	0	0	0	0	0	0	22,104	10
10a	Therapy	0	3,636	0	0	0	0	0	0	0	0	0	3,636	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>25,740</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>25,740</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	11,389	0	0	0	0	0	0	0	0	0	11,389	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,301)	(162,834)	0	10,750	0	0	0	0	0	0	0	(154,385)	19
20	Fees, Subscriptions & Promotions	(30,375)	2,474	0	0	0	0	0	0	0	0	0	(27,901)	20
21	Clerical & General Office Expenses	(16,436)	(96,000)	63,095	0	0	0	0	0	0	0	0	(49,341)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,300	0	0	0	0	0	0	0	0	1,300	23
24	Travel and Seminar	0	0	48	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	0	0	7,743	0	0	0	0	0	0	0	0	7,743	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,494	0	0	0	0	0	0	0	0	1,494	26
27	Other (specify):*	(19,891)	0	33,725	0	0	0	0	0	0	0	0	13,834	27
28	<b>TOTAL General Administration</b>	<b>(69,003)</b>	<b>(244,971)</b>	<b>107,405</b>	<b>10,750</b>	<b>0</b>	<b>(195,819)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(69,775)</b>	<b>(209,282)</b>	<b>107,405</b>	<b>10,750</b>	<b>0</b>	<b>(160,902)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,513	0	14,180	50,507	0	0	0	0	0	0	0	67,200	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,785)	0	29,541	162,415	0	0	0	0	0	0	0	179,171	32
33	Real Estate Taxes	0	0	4,878	0	0	0	0	0	0	0	0	4,878	33
34	Rent-Facility & Grounds	0	0	0	(255,221)	0	0	0	0	0	0	0	(255,221)	34
35	Rent-Equipment & Vehicles	0	0	5,394	0	0	0	0	0	0	0	0	5,394	35
36	Other (specify):*	0	(12,600)	0	0	0	0	0	0	0	0	0	(12,600)	36
37	<b>TOTAL Ownership</b>	<b>(10,272)</b>	<b>(12,600)</b>	<b>53,993</b>	<b>(42,299)</b>	<b>0</b>	<b>(11,178)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(80,047)</b>	<b>(221,882)</b>	<b>161,398</b>	<b>(31,549)</b>	<b>0</b>	<b>(172,080)</b>	<b>45</b>						

**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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					SKOKIE	REAL ESTATE

**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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 60,000	CAREPLUS MGMT INC			(60,000)	1
2	V	19	ADMIN. CONSULTANT FEES	150,000	" "			(150,000)	2
3	V	19	DATA PROCESSING FEES	23,448	" "			(23,448)	3
4	V	21	CLERICAL FEES	96,000	" "			(96,000)	4
5	V	36	OFFICE RENT	12,600	" "			(12,600)	5
6	V	5	UTILITIES		" "		58	58	6
7	V	6	MAINTENANCE		" "		9,867	9,867	7
8	V	7	SECURITY		" "		24	24	8
9	V	10	NURSING		" "		22,104	22,104	9
10	V	10a	THERAPY		" "		3,636	3,636	10
11	V	17	ADMIN		" "		71,389	71,389	11
12	V	19	PROFESSIONAL FEES		" "		10,614	10,614	12
13	V	20	DUES/LICENSES/WANT ADS		" "		2,474	2,474	13
14	Total		\$ 342,048				\$ 120,166	\$ * (221,882)	14

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

**VII. RELATED PARTIES (continued)**

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OFFICE	\$	CAREPLUS MGMT INC		\$ 63,095	\$ 63,095
16	V	23 SEMINARS		" "		1,300	1,300
17	V	24 IN-STATE TRAVEL/LODGING		" "		48	48
18	V	25 TRANSPORTATION		" "		7,743	7,743
19	V	26 INSURANCE		" "		1,494	1,494
20	V	27 EMPLOYEE BENEFITS		" "		33,725	33,725
21	V	30 SL DEPRECIATION		" "		5,795	5,795
22	V	32 INTEREST		" "		28,491	28,491
23	V	33 REAL ESTATE TAX		" "		4,878	4,878
24	V	35 EQUIPMENT RENT		" "		5,394	5,394
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		8,385	8,385
36	V	32 INTEREST		" "		1,050	1,050
37	V						
38	V						
39	Total		\$			\$ 161,398	\$ * 161,398

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

VII. RELATED PARTIES (continued)

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 255,221	PRAIRIE VILLAGE HEALTHCARE CENTER LLC		\$	(255,221)
16	V	30 SL DEPRECIATION		" "		50,507	50,507
17	V	32 INTEREST		" "		149,219	149,219
18	V	32 MIP INSURANCE		" "		13,196	13,196
19	V	19 ACCOUNTING FEES		" "		10,750	10,750
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 255,221			\$ 223,672	\$ * (31,549)

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	<b>CAREPLUS MGMT ALLOCATIONS:</b>								\$	1	
2	<b>SHERWIN RAY</b>	<b>PRESIDENT</b>	<b>ADMIN/FINANCE</b>		<b>SEE ATTACHED</b>	<b>4.7</b>	<b>7.80</b>	<b>SALARY</b>	<b>15,216</b>	<b>17-7</b>	2
3	<b>JAKOB BAKST</b>	<b>DIR OPERAT'NS</b>	<b>ADMIN/CONS.</b>		<b>SCHEDULES</b>	<b>4.7</b>	<b>7.80</b>	<b>" "</b>	<b>15,216</b>	<b>17-7</b>	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	<b>\$ 30,432</b>		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 VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CAREPLUS MANAGEMENT INC  
 Street Address 8320 SKOKIE BLVD  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847)329-1555  
 Fax Number ( 847)329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	373,906	10 FACILITIES	\$ 739	\$ 29,177	29,177	\$ 58	1
2	6	MAINTENANCE	373,906	10 FACILITIES	126,444	52,396	29,177	9,867	2
3	7	SECURITY	373,906	10 FACILITIES	308		29,177	24	3
4	10	NURSING	373,906	10 FACILITIES	283,260	283,260	29,177	22,104	4
5	10a	THERAPY	373,906	10 FACILITIES	46,604	46,472	29,177	3,636	5
6	17	ADMIN SALARIES	373,906	10 FACILITIES	914,862	914,862	29,177	71,389	6
7	19	PROFESSIONAL FEES	373,906	10 FACILITIES	136,016		29,177	10,614	7
8	20	DUES/LICENSES/WANT ADS	373,906	10 FACILITIES	31,710		29,177	2,474	8
9	21	OFFICE EXPENSES	373,906	10 FACILITIES	808,558	628,409	29,177	63,095	9
10	23	SEMINARS	373,906	10 FACILITIES	16,659		29,177	1,300	10
11	24	TRAVEL	373,906	10 FACILITIES	612		29,177	48	11
12	25	TRANSPORTATION	373,906	10 FACILITIES	99,225		29,177	7,743	12
13	26	INSURANCE	373,906	10 FACILITIES	19,140		29,177	1,494	13
14	27	EMPLOYEE BENEFITS	373,906	10 FACILITIES	432,184		29,177	33,725	14
15	30	SL DEPRECIATION	373,906	10 FACILITIES	74,261		29,177	5,795	15
16	32	INTEREST-TAG MTG/LOC/EQ LOAN	373,906	10 FACILITIES	365,115		29,177	28,491	16
17	33	REAL ESTATE TAX	373,906	10 FACILITIES	62,515		29,177	4,878	17
18	35	EQUIP RENT/AUTO LEASE	373,906	10 FACILITIES	69,127		29,177	5,394	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,487,339	\$ 1,925,399		\$ 272,129	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	<b>RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC</b>				\$	\$			\$	1										
2	HEARTLAND	X	MORTGAGE	\$16,072.41	11/03	2,830,700	2,617,282	10/33	5.5000	146,663	2									
3	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN	11/03	76,676	63,577	10/33		2,556	3									
4	MIP INSURANCE	X	MORTGAGE INSURANCE							13,196	4									
5											5									
<b>Working Capital</b>																				
6	INSURANCE FINANCING	X	INSUR. FINANCE							2,812	6									
7	<b>CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC/EQ LOAN</b>									28,491	7									
8	<b>CAREPLUS REHAB ALLOCATION: EQUIP LOAN</b>									1,050	8									
9	<b>TOTAL Facility Related</b>			\$16,072.41		\$ 2,907,376	\$ 2,680,859			\$ 194,768	9									
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC	X	LATE FEES							6,795	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 6,795	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 2,907,376	\$ 2,680,859			\$ 201,563	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,196 Line # 32-7

\* 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>27,300</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.)		\$	<b>21,455</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(5,845)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>21,670</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>15,825</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>23,687</b>	8
	2004	<b>24,815</b>	9
	2005	<b>25,752</b>	10
	2006	<b>27,034</b>	11
	2007	<b>21,455</b>	12

<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

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL.**

**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 VILLAGE HEALTHCARE CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0042671

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**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>09-17-100-012</u>	<u>NURSING HOME</u>	\$ <u>21,455.48</u>	\$ <u>21,455.48</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21,455.48</u>	\$ <u>21,455.48</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.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LLC</u>				<u>1</u>
2	<u>NURSING HOME: ACRES</u>	<u>8,686</u>	<u>1997</u>	<u>170,000</u>	<u>2</u>
3	<b>TOTALS</b>	<u>8,686</u>		<u>\$ 170,000</u>	<u>3</u>

Facility Name &amp; ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	<b>RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:</b>			\$	\$		\$	\$	\$	4
5	126	1997		1,114,539	28,577	39	28,577		327,466	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	ELECTRIC PANEL IN BOILER ROOM	1997		1,192	31	39	31		358	9
10	NURSE CALL SYSTEM	1997		17,863	458	39	458		5,228	10
11	40 TON A/C AND GAS LINE	1997		114,953	2,947	39	2,947		33,278	11
12	NEW ROOF	1997		35,981	923	39	923		10,345	12
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS	1997		18,875	484	39	484		5,425	13
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK	1997		44,010	1,128	39	1,128		12,549	14
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL	1997		165,706	4,249	39	4,249		47,271	15
16	FLOOR TILE	1997		35,928	921	39	921		10,169	16
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPER RAIL	1997		52,605	1,349	39	1,349		14,895	17
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW TREATM	1998		58,466	1,500	39	1,500		16,112	18
19	TILING / FLOORING / DOORS	1998		36,939	948	39	948		10,113	19
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS	1998		69,378	1,778	39	1,778		18,889	20
21	GENERATOR	1998		21,049	540	39	540		5,693	21
22	JFK CONTEMPORARY DESIGNS	1999		3,549	91	39	91		823	22
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES	2000		9,164	333	27.5	333		2,768	23
24	SHAYMAN,SALK ARENSON SETTLEMENT / PUMP	2001		54,531	1,982	27.5	1,983	1	15,418	24
25	NEW ROOF / FIRE SUPPRESSION SYSTEM / HOOD SYSTEM	2008		128,307	923	27.5	923		923	25
26	CONCRETE SIDEWALKS	2008		5,860	195	15	195		195	26
27	<b>PRAIRIE VILLAGE HEALTHCARE CENTER INC:</b>									27
28	CONCRETE WORK / DRYWALL / DOORS	2002		4,490	163	27.5	163		1,002	28
29	DOOR INSTALLATIONS / 6 VENTILATOR RECEPTACLES	2003		9,733	353	27.5	354	1	1,949	29
30	CONCRETE SLABS OUTSIDE EXIT DOORS	2003		3,350	223	15	223		1,227	30
31	OUTLET INSTALLATION AND REWIRING	2004		5,343	194	27.5	194		962	31
32	SIDEWALKS	2005		4,475	298	15	298		1,043	32
33	SHOWER REMODEL / ROOFING	2006		11,421	416	27.5	415	(1)	994	33
34	PAVING	2006		1,600	107	15	107		267	34
35	ROOFTOP A/C COMPRESSOR/HEAT EXCHANGER	2007		3,530	129	27.5	128	(1)	157	35
36	SIDEWALK / BUILDING SIGN	2007		3,891	259	15	260		390	36

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

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

See Page 12A, Line 70 for total

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	RELATED PARTY ALLOCATION - CAREPLUS MGMT								48
49	2004	36,308	1,220	39	1,220		3,930	49	
50	2004	14,264	923	39	923		2,525	50	
51	2007		5	39	5			51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 2,087,300	\$ 53,647		\$ 53,648	\$ 552,364	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	\$ 190,440	\$ 3,729	\$ 13,799	\$ 10,070	8-15 YRS	\$ 134,650	71
72	Current Year Purchases	13,583	8,149	657	(7,492)	8-15 YRS	657	72
73	Fully Depreciated Assets	2,561	66		(66)	8 YRS	2,561	73
74	<b>**REL'D PARTY-SL DEPN:CAREPL MGT, 3,647/CP REHAB, 8,385 /PRAIRIE VILL LLC, 1,150</b>		13,182	13,182		8-15 YRS		74
75	TOTALS	\$ 206,584	\$ 25,126	\$ 27,638	\$ 2,512		\$ 137,868	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)	\$ 2,463,884	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,773	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,286	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,513	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 690,232	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					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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 - RELATED PARTY**

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	<b>TOTAL</b>				\$			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: \$ **19,164** Description: **SEE SCHEDULE ATTACHED**

(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	ACTIVITY/HSKP/	2005 CHEVY	\$ 684.49	\$ 8,214	17
18	MAINT/BANKING/				18
19	ADMIN/ETC				19
20					20
21	<b>TOTAL</b>		\$ 684.49	\$ 8,214	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	39-3	hrs	\$		\$ 73,858	\$		\$ 73,858	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,303			21,303	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			62,743			62,743	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				108,953		108,953	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB/OTHER SERVICES Other (specify):	39-2					6,875		6,875	13
14	<b>TOTAL</b>			\$		\$ 157,904	\$ 115,828		\$ 273,732	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 VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 1,001	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (50,000) )	886,014		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	79,476		5
6	Prepaid Insurance	65,025		6
7	Other Prepaid Expenses	591		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,094,710	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	50,394		15
16	Equipment, at Historical Cost	204,024		16
17	Accumulated Depreciation (book methods)	(201,829)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 52,589	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,147,299	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 645,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	275		28
29	Short-Term Notes Payable	155,407		29
30	Accrued Salaries Payable	115,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,066		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,670		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 949,929	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>DUE TO LLC</b>	74,082		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 74,082	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,024,011	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 123,288	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,147,299	\$	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>104,386</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>ROUNDING</b>	<b>(1)</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>104,385</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>18,903</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>18,903</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>123,288</b>	<b>24</b> *

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

Facility Name &amp; ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	\$ 3,744,466	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,744,466	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	5,990	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,990	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,750,456	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	806,114	31
32	Health Care	1,240,533	32
33	General Administration	973,973	33
	<b>B. Capital Expense</b>		
34	Ownership	334,717	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	273,732	35
36	Provider Participation Fee	69,174	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>	33,310	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,731,553	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	18,903	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 18,903	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.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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 VILLAGE HEALTHCARE CENTER**

# **0042671**

Report Period Beginning: **01/01/2008**

Ending:

**12/31/2008**

**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	1,986	2,151	\$ 63,027	\$ 29.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,465	4,845	104,165	21.50	3
4	Licensed Practical Nurses	19,014	20,110	352,331	17.52	4
5	CNAs & Orderlies	37,152	39,547	374,118	9.46	5
6	CNA Trainees					6
7	Licensed Therapist	1,322	1,430	29,775	20.82	7
8	Rehab/Therapy Aides	2,982	3,129	36,230	11.58	8
9	Activity Director	1,833	1,983	19,593	9.88	9
10	Activity Assistants	2,907	3,138	24,039	7.66	10
11	Social Service Workers	1,791	1,892	28,281	14.95	11
12	Dietician					12
13	Food Service Supervisor	2,870	3,149	41,846	13.29	13
14	Head Cook	5,958	6,290	50,823	8.08	14
15	Cook Helpers/Assistants	5,968	6,441	50,308	7.81	15
16	Dishwashers					16
17	Maintenance Workers	4,831	6,118	47,432	7.75	17
18	Housekeepers	11,514	12,746	99,108	7.78	18
19	Laundry	6,275	7,062	55,157	7.81	19
20	Administrator	2,093	2,237	65,645	29.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,135	2,244	22,442	10.00	23
24	Clerical	1,867	1,962	19,622	10.00	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	2,173	2,355	23,926	10.16	31
32	Other Health C: <u>MDS/CPC</u>	1,191	1,334	13,794	10.34	32
33	Other(specify) <u>MARKETING</u>	1,361	1,372	19,891	14.50	33
34	TOTAL (lines 1 - 33)	121,688	131,535	\$ 1,541,553 *	\$ 11.72	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	M	\$ 5,100	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	2,193	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	80	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,956	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,129		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

# 0042671

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 219 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,174  
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. \$ 18,995 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees