

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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

<p><b>I. IDPH License ID Number:</b> <u>0018044</u></p> <p><b>Facility Name:</b> <u>PRAIRIEVIEW LUTHERAN HOME</u></p> <p><b>Address:</b> <u>PO BOX 4, CORNER OF NORTH &amp; 4TH DANFORTH</u> <u>60930</u>          Number City Zip Code</p> <p><b>County:</b> <u>IROQUOIS</u></p> <p><b>Telephone Number:</b> <u>815-269-2970</u> Fax # <u>815-269-2930</u></p> <p><b>HFS ID Number:</b> <u>362735789001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>2/14/74</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>KAREN SIPPEL</u> <b>Telephone Number:</b> <u>815-269-2970</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>KAREN SIPPEL</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SHERILYN K RABIDEAU</u> <u>CPA</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u></td> </tr> <tr> <td>(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE          ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>KAREN SIPPEL</u> (Date) _____		(Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>SHERILYN K RABIDEAU</u> <u>CPA</u>	(Firm Name & Address) <u>FOX CPA GROUP, LTD</u> <u>204 E CHERRY STREET, SUITE 300, WATSEKA, IL 60970</u>	(Telephone) <u>815-432-3126</u> Fax # <u>815-432-6061</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	6,339	24,013	1,721	32,073	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,339	24,013	1,721	32,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.51%

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

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

OUTPATIENT THERAPY, DAY CARE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 02/14/74

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 20 and days of care provided \_\_\_\_\_

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **PRAIRIEVIEW LUTHERAN HOME** # **0018044** Report Period Beginning: **1/1/09** Ending: **12/31/09**

**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	370,511	23,554	8,578	402,643		402,643		402,643		1
2	Food Purchase		221,920		221,920	(14,233)	207,687		207,687		2
3	Housekeeping	165,420	37,357		202,777		202,777		202,777		3
4	Laundry	82,258	14,289		96,547		96,547		96,547		4
5	Heat and Other Utilities			125,355	125,355		125,355		125,355		5
6	Maintenance	110,862	6,619	53,954	171,435		171,435		171,435		6
7	Other (specify):*					3,294	3,294		3,294		7
8	<b>TOTAL General Services</b>	<b>729,051</b>	<b>303,739</b>	<b>187,887</b>	<b>1,220,677</b>	<b>(10,939)</b>	<b>1,209,738</b>		<b>1,209,738</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,529	12,529	(7,729)	4,800		4,800		9
10	Nursing and Medical Records	2,180,778	212,355	10,068	2,403,201	(8,049)	2,395,152	(4,247)	2,390,905		10
10a	Therapy			306,553	306,553		306,553		306,553		10a
11	Activities	215,297	3,670	3,603	222,570		222,570		222,570		11
12	Social Services	35,500	70	1,600	37,170		37,170		37,170		12
13	CNA Training										13
14	Program Transportation					684	684		684		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,431,575</b>	<b>216,095</b>	<b>334,353</b>	<b>2,982,023</b>	<b>(15,094)</b>	<b>2,966,929</b>	<b>(4,247)</b>	<b>2,962,682</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,550			53,550		53,550		53,550		17
18	Directors Fees										18
19	Professional Services			55,645	55,645	(270)	55,375	(6,280)	49,095		19
20	Dues, Fees, Subscriptions & Promotions			41,463	41,463	1,295	42,758	(29,036)	13,722		20
21	Clerical & General Office Expenses	248,893	28,269	106,933	384,095	(1,430)	382,665	(17,279)	365,386		21
22	Employee Benefits & Payroll Taxes			980,973	980,973	26,987	1,007,960		1,007,960		22
23	Inservice Training & Education					2,669	2,669		2,669		23
24	Travel and Seminar			12,902	12,902	(3,218)	9,684		9,684		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,671	46,671		46,671		46,671		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>302,443</b>	<b>28,269</b>	<b>1,244,587</b>	<b>1,575,299</b>	<b>26,033</b>	<b>1,601,332</b>	<b>(52,595)</b>	<b>1,548,737</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,463,069</b>	<b>548,103</b>	<b>1,766,827</b>	<b>5,777,999</b>		<b>5,777,999</b>	<b>(56,842)</b>	<b>5,721,157</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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			203,215	203,215		203,215		203,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,600	5,600		5,600	(4,007)	1,593			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			208,815	208,815		208,815	(4,007)	204,808			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			26,312	26,312		26,312		26,312			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			76,682	76,682		76,682		76,682			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,463,069	548,103	2,052,324	6,063,496		6,063,496	(60,849)	6,002,647			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,247)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,007)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,280)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,279)	21		24
25	Fund Raising, Advertising and Promotional	(28,506)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(530)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (60,849)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (60,849)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

PRAIRIEVIEW LUTHERAN HOME

ID# 0018044

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME# 0018044

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>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	(4,247)	0	0	0	0	0	0	0	0	0	0	(4,247)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(4,247)</b>	<b>0</b>	<b>(4,247)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,280)	0	0	0	0	0	0	0	0	0	0	(6,280)	19
20	Fees, Subscriptions & Promotions	(29,036)	0	0	0	0	0	0	0	0	0	0	(29,036)	20
21	Clerical & General Office Expenses	(17,279)	0	0	0	0	0	0	0	0	0	0	(17,279)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(52,595)</b>	<b>0</b>	<b>(52,595)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(56,842)</b>	<b>0</b>	<b>(56,842)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME# 0018044

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,007)	0	0	0	0	0	0	0	0	0	0	(4,007)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,007)</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>(4,007)</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>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(60,849)</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>(60,849)</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
N/A						

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

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

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

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

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning:

1/1/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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										
										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		X	ADDITIONAL 32 BEDS	VARIES	3/21/96	\$ 1,500,000	\$	09/1/10	0.0600	\$ 5,600	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9						\$ 1,500,000	\$			\$ 5,600	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14						\$	\$			\$	14								
15						\$ 1,500,000	\$			\$ 5,600	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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





Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning:

1/1/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 49,200 B. General Construction Type: Exterior BRICK Frame STEEL & BRICK Number of Stories 1

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

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

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

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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: 1,189 2. Number of Years Over Which it is Being Amortized: 30  
 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>BLDG/GROUNDS</u>	<u>304,920</u>	<u>1971</u>	<u>\$ 9,115</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>304,920</b>		<b>\$ 9,115</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	60			1973	\$ 649,963	\$ 13,749	40	\$ 13,749	\$	\$ 494,244	4
5				1995	1,011,406	25,285	40	25,285		369,470	5
6	32			1996	1,834,874	45,872	40	45,872		581,048	6
7											7
8											8
	<b>Improvement Type**</b>										
9		FULLY DEPRECIATED			381,514		15			381,514	9
10		RENOVATION-NURSES STATION		1989	237,555	10,748	VARIOUS	10,748		216,319	10
11		REMODELING		1991	3,303	132	25	132		2,480	11
12		PARKING LOT/SIDEWALK		1993	19,868					19,868	12
13		TREATMENT PLANT		1994	225,522	11,276	20	11,276		171,020	13
14		1995 IMPROVEMENTS		1995	148,653	5,617	VARIOUS	5,617		116,209	14
15		1996 IMPROVEMENTS		1996	43,886	840	VARIOUS	840		23,975	15
16		1997 IMPROVEMENTS		1997	155,986	5,530	VARIOUS	5,530		155,986	16
17		1998 IMPROVEMENTS		1998	72,034	4,491	VARIOUS	4,491		52,803	17
18		RISER/SEAL TREATMENT PLANT		2002	1,090	73	15	73		584	18
19		2003 IMPROVEMENTS		2003	116,240	2,460	VARIOUS	2,460		13,139	19
20		2004 IMPROVEMENTS		2004	31,669	722	VARIOUS	722		4,286	20
21		SIGN		2005	8,900	593	15	593		2,619	21
22		WATER SOFTNER		2005	9,667	967	10	967		4,190	22
23		FLOORING		2005	655	44	15	44		183	23
24		CEILING TILE FOR KITCHEN		2005	948	47	20	47		196	24
25		FLOORING IN 4 ROOMS		2005	3,770	189	20	189		756	25
26		FLOORING IN SHOWERS		2006	7,400	493	15	493		1,890	26
27		LOFT IN GARAGE		2006	580	15	40	15		55	27
28		FLOORING IN CLOSETS		2006	1,000	67	15	67		240	28
29		COUNTERTOP & STORAGE BOXES		2007	1,197	80	15	80		227	29
30		HVAC SYSTEM		2007	121,775	6,089	20	6,089		13,193	30
31		FLOORING-FAITH PLACE		2007	52,500	3,500	15	3,500		8,750	31
32		PARKING LOT		2008	9,500	475	20	475		633	32
33		COUNTERTOP NURSES STATION		2008	2,999	300	10	300		475	33
34		DOOR/FRAME KITCHEN		2008	2,275	114	20	114		180	34
35		RTU 12' T CARRIER ROOF TOP		2008	13,049	652	20	652		978	35
36		DOOR FRAME GUIDES		2008	1,353	158	20	158		224	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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 LCN CLOSURE ALARM PATIO	2008	\$ 1,750	\$ 88	20	\$ 88		\$ 117	37
38 HVAC VENTILATION SYSTEM	2008	83,299	2,082	40	2,082		2,429	38
39 TUB/SHOWER ROOM	2009	153,707	320	40	320		320	39
40 FIRE ALARM SYSTEM	2009	16,500	309	40	309		309	40
41 SPA TUB	2009	17,472	146	40	146		146	41
42 WINDOW SASHES	2009	1,381	58	10	58		58	42
43 ROOF TOP COMPRESSOR	2009	2,290	57	10	57		57	43
44 NEW ASPHALT	2009	7,780	162	20	162		162	44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,455,310	\$ 143,800		\$ 143,800		\$ 2,641,332	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 506,613	\$ 57,964	\$ 57,964	\$	10	\$ 294,131	71
72	Current Year Purchases	13,364	501	501		10	501	72
73	Fully Depreciated Assets	586,296					586,296	73
74								74
75	<b>TOTALS</b>	\$ 1,106,273	\$ 58,465	\$ 58,465	\$		\$ 880,928	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RES TRANSPORTATION	1993 FORD VAN	1993	\$ 39,000	\$	\$			\$ 39,000	76
77	RES TRANSPORTATION	1993 FORD VAN	2003	9,500	950	950		10	6,017	77
78										78
79										79
80	<b>TOTALS</b>			\$ 48,500	\$ 950	\$ 950	\$		\$ 45,017	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,619,198	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,215	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,215	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,567,277	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND DONATED TO BE USED	\$ 35,540	\$	\$	86
87	FOR EXPANSION				87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$ 35,540	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6								6
7	<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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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>
--	---	--

**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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	1,475	\$ 102,148	\$ 869	1,475	\$ 103,017	1
2	Licensed Speech and Language Development Therapist		hrs		315	19,218		315	19,218	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,535	185,140	674	2,535	185,814	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	4,325	\$ 306,506	\$ 1,543	4,325	\$ 308,049	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

As of **12/31/09**

(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	\$ 253,528	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	720,751		3
4	Supply Inventory (priced at <u>COST</u> )	28,854		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,804		6
7	Other Prepaid Expenses	18,288		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM OTHERS</u>	203,368		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,239,593	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,655		13
14	Buildings, at Historical Cost	4,994,531		14
15	Leasehold Improvements, at Historical Cost	269,602		15
16	Equipment, at Historical Cost	1,310,410		16
17	Accumulated Depreciation (book methods)	(3,567,277)		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 (sum of lines 11 thru 23)</b>	\$ 3,051,921	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,291,514	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 338,949	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,197		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,881		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			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 (sum of lines 26 thru 37)</b>	\$ 593,027	\$	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	<u>OTHER ACCRUALS</u>	4,315		43
44	<u>DEFERRED REVENUE</u>	390,977		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 395,292	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 988,319	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,303,195	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,291,514	\$	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,843,579</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,843,579</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>98,510</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>98,510</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>FOUNDATION TRANSFERS</b>	<b>361,106</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>361,106</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,303,195</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 6,205,492	1
2	Discounts and Allowances for all Levels	(408,166)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,797,326	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	266,802	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 266,802	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	26,147	13
14	Non-Patient Meals	19,258	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>	\$ 45,405	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,007	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,007	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>SIU/ADMIN FEE/MISC</b>	52,975	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 52,975	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,166,515	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,220,677	31
32	Health Care	2,982,023	32
33	General Administration	1,575,299	33
<b>B. Capital Expense</b>			
34	Ownership	208,815	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	26,312	35
36	Provider Participation Fee	50,370	36
<b>D. Other Expenses (specify):</b>			
37	<b>LOSS ON ASSET DISPOSAL</b>	4,509	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,068,005	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	98,510	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 98,510	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

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

# **0018044**

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	3,399	3,711	\$ 105,064	\$ 28.31	1
2	Assistant Director of Nursing	3,962	4,305	100,326	23.30	2
3	Registered Nurses	12,156	13,080	278,069	21.26	3
4	Licensed Practical Nurses	25,596	27,020	494,220	18.29	4
5	CNAs & Orderlies	93,737	100,999	1,162,331	11.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,952	2,201	28,399	12.90	8
9	Activity Director	1,880	2,080	41,914	20.15	9
10	Activity Assistants	15,805	16,923	175,639	10.38	10
11	Social Service Workers	1,800	2,080	35,500	17.07	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	37,425	17.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,609	37,837	334,165	8.83	15
16	Dishwashers					16
17	Maintenance Workers	5,191	5,778	110,862	19.19	17
18	Housekeepers	14,796	16,079	165,420	10.29	18
19	Laundry	7,883	8,548	82,258	9.62	19
20	Administrator	1,184	1,310	53,550	40.88	20
21	Assistant Administrator					21
22	Other Administrative	6,432	7,214	139,845	19.39	22
23	Office Manager					23
24	Clerical	8,207	8,645	109,048	12.61	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	804	791	9,034	11.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,273	260,681	\$ 3,463,069 *	\$ 13.28	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	165	\$ 8,578	1-3	35
36	Medical Director	192	4,800	9-3	36
37	Medical Records Consultant	6	270	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,783	11-3	44
45	Social Service Consultant	26	1,600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	429	\$ 17,331		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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
KAREN SIPPEL	ADMIN		\$ 53,550	Workers' Compensation Insurance	\$ 213,387	IDPH License Fee	\$		
				Unemployment Compensation Insurance	15,774	Advertising: Employee Recruitment		2,689	
				FICA Taxes	259,411	Health Care Worker Background Check			
				Employee Health Insurance	450,489	(Indicate # of checks performed <u>69</u> )		710	
				Employee Meals	19,258	Patient Background Checks <u>72</u>		720	
				Illinois Municipal Retirement Fund (IMRF)*		DUES		9,085	
				EMPLOYEE PHYSICALS	7,729	SUBSCRIPTIONS		2,350	
				MEDICAL REIMBURSEMENT PLAN	2,000	NEWSLETTER VIEWS		9,850	
				INCENTIVES	2,684	PUBLIC RELATIONS/ADV		17,327	
				PENSION	37,228	NONDEDUCTIBLE DUES/SUB		(1,670)	
						Less: Public Relations Expense		(13,996)	
						Non-allowable advertising		(12,840)	
						Yellow page advertising		(503)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,550	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,007,960	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,722
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			\$	Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$	
							In-State Travel	2,330	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	8,038	
C. Professional Services			Amount						
Vendor/Payee	Type		\$						
DECK & BARON	LEGAL		360						
SUSAN LYNCH	LEGAL		5,330						
FOX CPA GROUP	AUDIT		6,150						
KELLY, COX PAINTER	ACCOUNTANTS		17,815						
BENEFIT PLANNING CONS	FLEX/HRA		3,477						
CLIFTON GUNDERSON	PENSION AUDIT		8,900						
FR&R HEALTHCARE	MEDICARE CONS		3,687						
ACCUMED SERVICE	MEDICARE BILLING		3,731						
AMERICAN UNITED LIFE	PLAN ADMIN		1,715						
CAPITAL RESEARCH	PENSION PLAN ADMIN		1,050						
SEE ATTACHMENT	CONSULTING		1,960						
ARTISTRY MARKETING	NEW WEBSITE		1,200						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 55,375	TOTAL			\$		
							Entertainment Expense (agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 9,684	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>			\$	\$	\$	\$	\$	\$	\$	\$	\$								

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name &amp; ID Number PRAIRIEVIEW LUTHERAN HOME

# 0018044

Report Period Beginning:

1/1/09

Ending: 12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. LSN \$4958
- (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. \$ 55,251 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,258 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: FOX CPA GROUP, LTD
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**