

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0036277

Facility Name: Prairie Estates

Address: 403 North State Flora 62839
Number City Zip Code

County: Clay

Telephone Number: 618-662-9440 Fax # 618-662-4159

HFS ID Number:

Date of Initial License for Current Owners: 09/15/90

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 c 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Rita Armbrust Telephone Number: 618-548-0309
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/10 to 09/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Terry Elwood
(Title) President

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number Prairie Estates

0036277 Report Period Beginning: 10/01/10 Ending: 09/30/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,525			5,525	13
14	TOTALS	5,525			5,525	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.61%

D. How many bed-hold days during this year were paid by the Department? 178 (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)
N/A

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 09/15/90

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/31/91 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 09/30/11 Fiscal Year: 09/30/11

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	39,976	4,983	1,638	46,597		46,597		46,597			1
2	Food Purchase		44,731		44,731	(1,327)	43,404	60	43,464			2
3	Housekeeping	37,025	5,363		42,388		42,388	54	42,442			3
4	Laundry		682		682		682		682			4
5	Heat and Other Utilities			13,447	13,447		13,447	1,486	14,933			5
6	Maintenance	4,204	1,780	8,546	14,530		14,530	120	14,650			6
7	Other (specify):* GARBAGE P-U			825	825		825	12	837			7
8	TOTAL General Services	81,205	57,539	24,456	163,200	(1,327)	161,873	1,732	163,605			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	176,958	1,366	9,348	187,672		187,672		187,672			10
10a	Therapy											10a
11	Activities	24,614		423	25,037		25,037		25,037			11
12	Social Services	3,920			3,920		3,920		3,920			12
13	CNA Training											13
14	Program Transportation			6,871	6,871	(1,419)	5,452		5,452			14
15	Other (specify):* HAB AIDE TRAININ	2,810	50		2,860		2,860		2,860			15
16	TOTAL Health Care and Programs	208,302	1,416	16,642	226,360	(1,419)	224,941		224,941			16
	C. General Administration											
17	Administrative	57,023			57,023		57,023	15,000	72,023			17
18	Directors Fees							2,250	2,250			18
19	Professional Services			91,228	91,228		91,228	1,473	92,701			19
20	Dues, Fees, Subscriptions & Promotions			97	97		97	696	793			20
21	Clerical & General Office Expenses	6,368	6,513		12,881		12,881	3,745	16,626			21
22	Employee Benefits & Payroll Taxes			27,546	27,546	1,327	28,873	15,120	43,993			22
23	Inservice Training & Education			32	32		32		32			23
24	Travel and Seminar			501	501		501		501			24
25	Other Admin. Staff Transportation			560	560	183	743	1,133	1,876			25
26	Insurance-Prop.Liab.Malpractice			5,423	5,423		5,423	579	6,002			26
27	Other (specify):*											27
28	TOTAL General Administration	63,391	6,513	125,387	195,291	1,510	196,801	39,996	236,797			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	352,898	65,468	166,485	584,851	(1,236)	583,615	41,728	625,343			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			24,002	24,002		24,002	1,168	25,170			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,200	4,200			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	TOTAL Ownership			24,002	24,002		24,002	7,768	31,770			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,236	1,236		1,236			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,370	34,370		34,370		34,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			34,370	34,370	1,236	35,606		35,606			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	352,898	65,468	224,857	643,223		643,223	49,496	692,719			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50)	L20 C3		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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	49,546	Pg 6A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 49,546		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 49,496		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		\$ 1,236	L14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,236		47

Prairie Estates

ID# 0036277

Report Period Beginning: 10/01/10

Ending: 09/30/11

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
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

09/30/11

[illegible]

Summary B

09/30/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Richland Manor	Olney	(Marion County Horizon Center)	Salem	Home Office

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		See attached 6A	\$ 49,546	Marion County Horizon Center	0.00%	\$ 99,092	\$ 49,546	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 49,546			\$ 99,092	\$ * 49,546	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	Terry Elwood	Director	Board Member	0.00	1,150	2	6.00	Director Fee	\$ 1,150	L18, C7	1
2	Amanda Miller	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18, C7	2
3	Julie Quinn	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,250		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 Estates # 0036277 Report Period Beginning: 10/01/10 Ending: 09/30/11

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 Marion County Horizon Center
Street Address 122 N Hotze Rd
City / State / Zip Code Salem, IL 62881
Phone Number (618-548-0309
Fax Number (618-548-3720

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Facilities	2	2	\$ 119	\$ 0	1	\$ 60	1
2	3	Housekeeping Supplies	Facilities	2	2	107	0	1	54	2
3	5	Utilities	Facilities	2	2	2,972	0	1	1,486	3
4	6	Maintenance Supplies	Facilities	2	2	240	0	1	120	4
5	7	Garbage Pick-up	Facilities	2	2	24	0	1	12	5
6	17	Management Fees	Facilities	2	2	30,000	0	1	15,000	6
7	18	Director Fees	Facilities	2	2	4,500	0	1	2,250	7
8	19	Accounting	Facilities	2	2	2,946	0	1	1,473	8
9	20	License Fees	Facilities	2	2	469	0	1	235	9
10	20	Dues & Subscriptions	Facilities	2	2	401	0	1	201	10
11	20	Employee Background Checks	Facilities	2	2	620	0	1	310	11
12	21	Telephone	Facilities	2	2	2,956	0	1	1,478	12
13	21	Office Supplies	Facilities	2	2	1,857	0	1	929	13
14	21	Computer Expense	Facilities	2	2	2,675	0	1	1,338	14
15	22	W/C Insurance	Facilities	2	2	19,182	0	1	9,591	15
16	22	Emp. Health Insurance	Facilities	2	2	5,479	0	1	2,740	16
17	22	State Unemployment Taxes	Facilities	2	2	5,577	0	1	2,789	17
18	25	Gas & Oil	Facilities	2	2	658	0	1	329	18
19	25	Trans. Repair & Maintenance	Facilities	2	2	1,607	0	1	804	19
20	26	Building Insurance	Facilities	2	2	1,157	0	1	579	20
21	30	Depreciation	Facilities	2	2	2,346	0	1	1,168	21
22	34	Other Rent	Facilities	2	2	8,400	0	1	4,200	22
23	35	Vehicle Rent	Facilities	2	2	4,800	0	1	2,400	23
24										24
25	TOTALS					\$ 99,092	\$		\$ 49,546	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						
	A. Directly Facility Related Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	9	
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	14	
15	TOTALS (line 9+line14)						\$	None	\$	None		\$	None	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

** 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

[illegible]

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

FACILITY NAME	<u>Prairie Estates</u>	COUNTY	<u>Clay</u>
FACILITY IDPH LICENSE NUMBER	<u>0036277</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Rita Armbrust</u>		
TELEPHONE	<u>618-548-0309</u>	FAX #:	<u>618-548-3720</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,514

B. General Construction Type: Exterior Vinyl Frame Wood & Brick Number of Stories One

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).

None

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>Facility</u>	<u>29,092</u>	<u>1991</u>	<u>\$ 7,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	29,092		\$ 7,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 512,954	\$ 20,426		\$ 20,426	\$	\$ 385,917	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	16		1991	1986	\$ 392,196	\$ 15,688	25	\$ 15,688	\$	\$ 316,373
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		1986		4,294		10			4,294
10	Walk & Driveway		1986		2,738		20			2,719
11	Decorating		1986		300		5			300
12	Carpet & Tile		1987		1,014		6			1,014
13	Drapes		1987		770		6			770
14	Landscaping		1991		1,111		10			1,111
15	Paving/Concrete		1991		11,838	492	20	492		11,838
16	Wood Deck		1991		1,174		15			1,174
17	Garage		1991		13,672		15			13,672
18	Landscaping		1991		2,369		10			2,369
19	Flooring		1994		1,721		15			1,721
20	Landscaping		1995		1,435		10			1,435
21	Vinyl Flooring		1998		3,468	231	15	231		3,100
22	Roof replacement (shingles)		2003		8,715	436	20	436		3,561
23	Replace Decking & substructure		2003		4,640	232	20	232		1,895
24	Bathroom Remodeling		2003		6,845	342	20	342		2,765
25	Bathroom Tub & shower replaced/remodeled		2004		8,598	430	20	430		3,189
26	Remodel Kitchen/cabinets		2005		4,906	327	15	327		2,098
27	Cabinets bathroom/laundry		2006		4,948	247	20	247		1,462
28	Plumbing kitchen area		2006		2,267	151	15	151		894
29	Bathroom Remodeling		2007		24,751	1,238	20	1,238		5,571
30	Heating duct repair/replacement		2007		7,649	510	15	510		2,167
31	Replace subfloor furnace room		2007		1,535	102	15	102		425
32										
33										
34										
35										
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

C. Equipment Costs-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	\$ 52,808	\$ 1,308	\$ 1,308	\$	10	\$ 50,901	71
72	Current Year Purchases	954	143	143		5	143	72
73	Fully Depreciated Assets							73
74	Home office equipment	519	74	74		7	83	74
75	TOTALS	\$ 54,281	\$ 1,525	\$ 1,525	\$		\$ 51,127	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Transportation	1999 Dodge Van	1999	\$ 23,106	\$	\$	\$	4	\$ 23,106	76
77	Used Handicapped Van	1999 Ford Ecoline Sport Van	2010	8,500	2,125	2,125		4	2,692	77
78		(with wheelchair lift)								78
79	Errands (Shared 50%)	2004 GMC Envoy	2010	5,250	1,094	1,094		4	1,094	79
80	TOTALS			\$ 36,856	\$ 3,219	\$ 3,219	\$		\$ 26,892	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 611,091 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,170 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,170 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)	\$ 463,936 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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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: Shivam Hotel, Inc.
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	Home Office	1987		3/09/92	4,200			5
6								6
7	TOTAL				\$ 4,200			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	Facility Transportation	2010 GMC Terrain	\$ 200.00	\$ 2,400	17
18					18
19					19
20					20
21	TOTAL		\$ 200.00	\$ 2,400	21

10. Effective dates of current rental agreement:

Beginning 3/09/2009

Ending 3/09/14

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

	Fiscal Year Ending	Annual Rent
12.	09/30/2012	\$ 4,200
13.	09/30/2013	\$ 4,200
14.	09/30/2014	\$ 4,200

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		50		50
3	Classroom Wages (a)		923		923
4	Clinical Wages (b)		1,477		1,477
5	In-House Trainer Wages (c)		410		410
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	2,860	\$	2,860
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,860		

(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.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(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.)

	1	2	3	4	5	6	7	8		
	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
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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	TOTAL			\$ None		\$ None	\$ None	None	\$ None	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 347,973	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,804		3
4	Supply Inventory (priced at cost)	2,752		4
5	Short-Term Investments	187,619		5
6	Prepaid Insurance	537		6
7	Other Prepaid Expenses	331		7
8	Accounts Receivable (owners or related parties)	53,931		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 689,947	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,000		13
14	Buildings, at Historical Cost	405,868		14
15	Leasehold Improvements, at Historical Cost	107,086		15
16	Equipment, at Historical Cost	76,322		16
17	Accumulated Depreciation (book methods)	(453,759)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 142,517	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 832,464	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,600	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,249		30
31	Accrued Taxes Payable (excluding real estate taxes)	398		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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 19,247	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,247	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 813,217	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 832,464	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 810,503	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 810,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,714	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,714	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 813,217	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 626,214	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 626,214	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	5,713	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	1,236	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,949	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,774	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,774	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 645,937	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	163,200	31
32	Health Care	226,360	32
33	General Administration	195,291	33
	B. Capital Expense		
34	Ownership	24,002	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 643,223	40
41	Income before Income Taxes (line 30 minus line 40)**	2,714	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,714	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,729	1,761	17,009	9.66	9
10	Activity Assistants	870	870	7,605	8.74	10
11	Social Service Workers	210	210	3,920	18.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,535	1,599	16,766	10.49	14
15	Cook Helpers/Assistants	2,416	2,528	23,210	9.18	15
16	Dishwashers					16
17	Maintenance Workers	180	182	4,204	23.10	17
18	Housekeepers	3,219	3,427	37,025	10.80	18
19	Laundry					19
20	Administrator	1,200	1,248	30,030	24.06	20
21	Assistant Administrator	1,734	1,798	23,073	12.83	21
22	Other Administrative	210	210	3,920	18.67	22
23	Office Manager					23
24	Clerical	602	706	6,368	9.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	980	1,020	21,622	21.20	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	15,222	15,686	155,336	9.90	30
31	Medical Records					31
32	Other Health Care: HAT TRAINER	24	24	410	17.08	32
33	Other(specify) HAB AIDE TRAINEE	260	260	2,400	9.23	33
34	TOTAL (lines 1 - 33)	30,391	31,529	\$ 352,898 *	\$ 11.19	34

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	26	\$ 1,638	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	216	4,741	L10 C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	48	3,600	L10 C3	47
48	Psychologist Consultant	1	113	L10 C3	48
49	TOTAL (lines 35 - 48)	291	\$ 10,092		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)	None	\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number
0036277

Report Period Beginning: 10/01/10

Page 21
Ending: 09/30/11

Prairie Estates

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Trena Briscoe, LNHA

Administrator

0%

\$ 30,030

Lisa Agee

Asst. Admn.

0%

23,073

Char Watton LNHA, MSW

Administrative

0%

3,920

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 57,023

B. Administrative - Other

Description

Amount

None

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Health Care Mgmt. Corp

Admn. Consulting Fees

\$ 91,200

Krehbiel & Associates

*Accounting

Clay County Advocate-Press

Non-discriminatory Notice

28

*Pass thru home office

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 91,228

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 9,676

Unemployment Compensation Insurance

2,789

FICA Taxes

27,003

Employee Health Insurance

2,740

Employee Meals

1,327

Illinois Municipal Retirement Fund (IMRF)*

Staff Flu shots

308

Staff TB Tests

150

Pass thru Home Office:

W/C Insurance=9591

Unemp Insurance = 2789

Employee Health Insurance = 2740

TOTAL (agree to Schedule V, line 22, col.8)

\$ 43,993

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

None

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

40

(Indicate # of checks performed 4)

Patient Background Checks

3

Advertising

50

Subscription

247

Vehicle licensing fees

151

CLIA lab license

75

Registration for Background Check

250

Less: Public Relations Expense

(50)

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 793

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Mileage

279

Meals

84

Hotel

73

Seminar Expense

Living Well, Dying Well

65

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 501

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28 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. \$ 34,370
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? Yes 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. \$ 1,327 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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,236
c. What percent of all travel expense relates to transportation of nurses and patients? 78.09%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

1 Employee Benefits and Payroll Taxes, Line 22	\$1,327	
Food Purchase, Line 2		\$1,327

To reclassify free employee meals from food costs to employee benefits

2 Medically Necessary Transportation, Line 38	\$1,236	
Program Transportation, Line 14		\$1,236

To reclassify medical transportation for clients per the separate DPA contract

3 Other Admn. Staff Transportation, Line 25	\$183	
Program Transportation, Line 14		\$183

According to the facility's 16-Passenger van mileage log, 3,590 miles were driven this fiscal year (110,869 less 107,279.)
Of that, 47 miles were for unloaded errand miles for the facility.
According to the facility's wheelchair van mileage log, 4,029 miles were driven this fiscal year (93,773 less 89,744.)
Of that, 156 miles were for unloaded errand miles for the facility.
Therefore:
Line 25 Other Admn. Travel = (47 +156 miles)/(3,590 + 4,029 miles) x \$6871 = \$183

Travel and Seminar, Line 24:

<u>Job Title</u>	<u>Date</u>	<u>Location</u>	<u>Title</u>	<u>Sponsor</u>	<u>Seminar Cost</u>	<u>Mileage Paid</u>	<u>Hotel Cost</u>	<u>Food Costs</u>	<u>Total Costs</u>
L.N.H.A.	10/12/10 - 10/13/10	Bloomington	"Transition to After School Pgms."	D.C.F.S.	\$65	\$165	\$73	\$55	\$292
L.N.H.A.	11/18/2010	Evansville	"Living Well, Dying Well"	Deaconess Hospital	\$0	\$114	\$0	\$29	\$142
					<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>0</u>
					\$65	\$279	\$73	\$84	<u>\$501</u>

Other Admn. Transportation, Line 25

Reimbursement to employees for administrative miles were reimbursed at a rate of \$.45/mile for the period 10/01/10 to 09/30/11. Detailed logs of these miles are maintained at the facility.

Tt miles reimbursed - 1,244 miles x \$.45/mile	\$560
Less miles re-classed to Travel & Seminar	\$0
Rep/Main, gas&oil for vehicles (fm home office)	\$1,133
203 miles logged onto vans for administrative use	<u>\$183</u>
Line 25, Column 8	<u>\$1,876</u>

Related Expense Allocation of Marion County Horizon Center

Schedule V Line Reference	Item	Total Marion County Horizon Center Expenses	% of Ownership	Allocation	
				Prairie Estates	Richland Manor
2	Food	\$119	0%	60	60
3	Housekeeping Supplies	\$107	0%	54	54
5	Utilities	\$2,972	0%	\$1,486	\$1,486
6	Maintenance Supplies	\$240	0%	\$120	\$120
7	Garbage Pick-up	\$24	0%	\$12	\$12
17	Management Fees	\$30,000	0%	\$15,000	\$15,000
18	Director Fees	\$4,500	0%	\$2,250	\$2,250
19	Accounting	\$2,946	0%	\$1,473	\$1,473
20	License fees	\$469	0%	\$235	\$235
20	Dues & Subscriptions	\$401	0%	\$201	\$201
20	Employee Background Checks	\$620	0%	\$310	\$310
21	Telephone	\$2,956	0%	\$1,478	\$1,478
21	Office Supplies	\$1,857	0%	\$929	\$929
21	Computer Expense	\$2,675	0%	\$1,338	\$1,338
22	W/C Insurance	\$19,182	0%	\$9,591	\$9,591
22	Emp. Health Ins.	\$5,479	0%	\$2,740	\$2,740
22	State Unemp Taxes	\$5,577	0%	\$2,789	\$2,789
25	Gas & Oil	\$658	0%	\$329	\$329
25	Trans. Rep & Main.	\$1,607	0%	\$804	\$804
26	Building Insurance	\$1,157	0%	\$579	\$579
30	Depreciation	\$2,336	0%	\$1,168	\$1,168
34	Other Rent	\$8,400	0%	\$4,200	\$4,200
35	Vehicle Rent	<u>\$4,800</u>	0%	<u>\$2,400</u>	<u>\$2,400</u>
		<u>\$99,082</u>		<u>\$49,546</u>	<u>\$49,546</u>

	#0036277 Prairie <u>Estates</u>	#0036285 Richland <u>Manor</u>	<u>Total</u>
Terry Elwood	\$1,150	\$1,150	\$2,300
Amanda Miller	\$550	\$550	\$1,100
Julie Quinn	<u>\$550</u>	<u>\$550</u>	<u>\$1,100</u>
Totals	<u>\$2,250</u>	<u>\$2,250</u>	<u>\$4,500</u>

	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Straight Line Depreciation</u>	<u>Adjustment</u>	<u>Component Life</u>	<u>Accm Depreciation</u>
Equipment (Purchased in Prior Years)						
Home Office	\$1,038	\$148			7	
% Home Office Allocated	<u>x.5</u>	<u>x.5</u>				
	\$519	\$74	\$74			\$83
Prairie Estates Equipment	<u>\$52,808</u>	<u>\$1,308</u>	<u>\$1,308</u>	0		<u>\$50,901</u>
Total XI-C, Line 71	\$53,327	\$1,382	\$1,382	0		\$50,984
Equipment (Current Year Purchases)						
Home Office					5	
% of Home Office Allocated	<u>x.5</u>	<u>x.5</u>				
				0		\$0
Prairie Estates Equipment	\$954	<u>\$143</u>	<u>\$143</u>	0	5	<u>\$143</u>
Total XI-C, Line 75		\$1,525	\$1,525			\$51,127

Breakdown of Individual Salary Costs

Schedule XX, Line 12:

Trena Briscoe's pay has been allocated as follows:

- LNHA - 50%
- QMRP - 36%
- Housekeeping - 7%
- Maintenance - 7%

Charlotte Watton's hours have been allocated as follows:

- Social Worker - 1/2 Salary
- Administrative - 1/2 Salary