

		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: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 South Chestnut Street Pana 62557
Number City Zip Code

County: Christian

Telephone Number: (217) 562-3996 Fax # (217) 562-4005

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2000

Type of Ownership:

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

☐ 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: Larry Templin Telephone Number: (309) 689-5869
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 1/1/2011 to 12/31/2011 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)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed)
(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 Rose Health Care Center

0045245 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>105</u>	Skilled (SNF)	<u>105</u>	<u>38,325</u>	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	<u>105</u>	TOTALS	<u>105</u>	<u>38,325</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,255</u>	<u>5,001</u>	<u>1,893</u>	<u>26,149</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,255</u>	<u>5,001</u>	<u>1,893</u>	<u>26,149</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.23%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location? Date started 3/1/1995

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 3/1/1995 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 105 and days of care provided 1,893

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number **Prairie Rose Health Care Center** # **0045245** Report Period Beginning: **1/1/2011** Ending: **12/31/2011**
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	
	A. General Services											
1	Dietary	129,196	20,816		150,012		150,012		150,012			1
2	Food Purchase		163,777		163,777		163,777	(8,393)	155,384			2
3	Housekeeping	129,934	15,672		145,606		145,606		145,606			3
4	Laundry	16,729	16,223		32,952		32,952		32,952			4
5	Heat and Other Utilities			105,994	105,994		105,994		105,994			5
6	Maintenance	32,617	8,675	24,937	66,229		66,229		66,229			6
7	Other (specify):* Home Off. Ben. All.											7
8	TOTAL General Services	308,476	225,163	130,931	664,570		664,570	(8,393)	656,177			8
	B. Health Care and Programs											
9	Medical Director			21,750	21,750		21,750		21,750			9
10	Nursing and Medical Records	1,339,258	124,703	7,000	1,470,961		1,470,961	(353)	1,470,608			10
10a	Therapy	179,794	52	185,150	364,996		364,996		364,996			10a
11	Activities	30,090	8		30,098		30,098	(470)	29,628			11
12	Social Services	34,485			34,485		34,485		34,485			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,583,627	124,763	213,900	1,922,290		1,922,290	(823)	1,921,467			16
	C. General Administration											
17	Administrative	43,754		231,246	275,000		275,000		275,000			17
18	Directors Fees											18
19	Professional Services			16,974	16,974		16,974		16,974			19
20	Dues, Fees, Subscriptions & Promotions			7,280	7,280		7,280		7,280			20
21	Clerical & General Office Expenses		4,576	47,558	52,134		52,134	(972)	51,162			21
22	Employee Benefits & Payroll Taxes			460,769	460,769		460,769		460,769			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,236	10,236		10,236		10,236			25
26	Insurance-Prop.Liab.Malpractice			52,473	52,473		52,473		52,473			26
27	Other (specify):* Home Off. Ben. All.											27
28	TOTAL General Administration	43,754	4,576	826,536	874,866		874,866	(972)	873,894			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,935,857	354,502	1,171,367	3,461,726		3,461,726	(10,188)	3,451,538			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			176,359	176,359		176,359	(29,954)	146,405			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			213,629	213,629		213,629	(3,042)	210,587			32
33	Real Estate Taxes			49	49		49	(49)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,989	28,989		28,989		28,989			35
36	Other (specify):*											36
37	TOTAL Ownership			419,026	419,026		419,026	(33,045)	385,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,781		65,781		65,781		65,781			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):* Non-allowable Costs	107,373	1,381	158,116	266,870		266,870	(266,870)				43
44	TOTAL Special Cost Centers	107,373	67,162	215,604	390,139		390,139	(266,870)	123,269			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,043,230	421,664	1,805,997	4,270,891		4,270,891	(310,103)	3,960,788			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	(8,393)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,161)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,954)	30		9
10	Interest and Other Investment Income	(288)	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	(17,907)	43		18
19	Entertainment				19
20	Contributions	(12,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,242)	43		24
25	Fund Raising, Advertising and Promotional	(3,556)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(130,602)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (310,103)		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (310,103)		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	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

ID# 0045245

Ending:

1/1/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (14,172)	43	1
2	X-Rays-Part A	(3,027)	43	2
3	Pet Expense	(1,225)	43	3
4	Special Events	(207)	43	4
5	Miscellaneous Revenue Offset-Office Supplies	(972)	21	5
6	Miscellaneous Revenue Offset-Nursing Supplies	(353)	10	6
7	Disallowed Marketing Salaries	(107,373)	43	7
8	Disallowed R.E. Taxes	(49)	33	8
9	Offset Transporation Revenue	(470)	11	9
10	Disallowed interest on IDES penalty	(2,754)	32	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(130,602)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[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
SJL Health Systems, Inc.	100	South Shore Health Care, LLC	Gary, Indiana	None		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X 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						\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 6A-Board of Directors

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

Secretary
Thomas Hammerton
3400 W. Brenwick Drive
Peoria, IL 61614

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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						\$	\$			1
2										2
3										3
4		N/A								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

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	Wells Fargo		X	Mortgage	\$21,167.65	12/01/02	\$ 3,580,869	\$ 3,183,582	11/01/35	0.0618	\$ 198,307	1	
2												2	
3								Interest Income Offset			(288)	3	
4								Amortization of Bond Issuance Cost			12,568	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,167.65		\$ 3,580,869	\$ 3,183,582			\$ 210,587	9	
	B. Non-Facility Related*												
10								Interest on IDES Penalty			2,754	10	
11								Disallow Interest on IDES Penalty			(2,754)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,580,869	\$ 3,183,582			\$ 210,587	15	

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2010		\$ 49	2
3. Under or (over) accrual (line 2 minus line 1).				\$ 49	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			Disallowed R.E. Taxes	(49)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006		8		
	2007	43	9		
	2008	48	10		
	2009	55	11		
	2010	49	12		
This entity is a not-for-profit and therefore does not get assessed taxes on its business assets.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Prairie Rose Health Care Center

COUNTY

Christian

FACILITY IDPH LICENSE NUMBER

0045245

CONTACT PERSON REGARDING THIS REPORT

Mark Petersen

TELEPHONE

(309)691-8113

FAX #:

(309) 691-8622

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-25-21-401-010-00	Land	\$ 49.18	\$ 49.18
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 49.18	\$ 49.18

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000

B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	121		1995	1976	\$ 1,068,665	\$	30	\$ 35,622	\$ 35,622	\$ 599,638	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363		30	32,345	32,345	811,328	9
10	1987 Additions			1987	110,922		29	3,825	3,825	91,534	10
11	1989 Additions			1989	2,219		10			2,219	11
12	1990 Additions			1990	4,295		30			4,295	12
13	1991 Additions			1991	134,283		7			134,283	13
14	1992 Additions			1992	17,130		7			17,130	14
15	1993 Additions			1993	24,239		7			24,239	15
16	1994 Additions			1994	10,559		7			10,559	16
17	1995 Additions			1995	14,617		15			14,617	17
18	1996 Additions			1996	305,057		12			305,057	18
19	1997 Additions			1997	23,542		10			23,542	19
20	Whirlpool Bath			1998	9,120		10			9,120	20
21	Lift, Bath Trolley			1998	3,850		10			3,850	21
22	Shower Room			1998	4,884		10			4,884	22
23	Entrance Doors			1998	2,358		20	118	118	1,563	23
24	Curtains			1998	6,102		5			6,102	24
25	Sidewalk & Pad			1999	1,484		15	99	99	1,245	25
26	Divide Receipts on Emergency Generator			1999	2,397		20	120	120	1,499	26
27	Med Room Cabinets and Counter Top			1999	2,008		20	100	100	1,204	27
28	Heat/Cool			2000	1,876		7			1,876	28
29	Door Alarms			2001	1,215		15	81	81	783	29
30	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	33,273	30
31	Wooded Doors			2001	1,900		15	127	127	1,279	31
32	Landscaping-Renovation Project			2001	1,174		10	(79)	(79)	1,174	32
33	Bituminous Parking Lot			2001	22,030		8			22,030	33
34											34
35											35
36											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

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replace Plumbing Fixtures	2002	\$ 2,490	\$	20	\$ 125	125	1,247	37
38	Therapy Room Remodel	2002	5,617		20	281	281	2,669	38
39	Remodel Medication/Utility Rooms	2002	7,909		20	395	395	3,755	39
40	2 Heating/Cooling Roof Top Units	2002	11,300		10	1,130	1,130	10,641	40
41	Breakroom Remodel	2002	3,106		10	311	311	2,926	41
42	Exterior Window Covering	2002	7,650		7			7,650	42
43	Lights for Therapy Room	2002	805		10	81	81	734	43
44	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	16,732	44
45	Fire Supression System	2004	1,540		10	154	154	1,091	45
46	Antenna	2004	2,944		10	294	294	2,304	46
47	Sign	2004	1,200		10	120	120	840	47
48	Carpet	2005	1,281		5		43	1,281	48
49	Sidewalks	2006	8,735		10	874	874	4,837	49
50	Duct Work	2007	5,120		15	342	342	1,539	50
51	Water Heater	2007	5,378		10	538	538	2,421	51
52	Sidewalks	2007	8,976		15	598	598	2,691	52
53	Water Heater & Duct Work	2008	4,850		10	485	485	1,698	53
54	Air Conditioner-Rooftop	2008	9,120		10	912	912	3,192	54
55	Plumbing Repair	2008	3,442		10	344	344	1,376	55
56	Ceramic Tile Replacement	2008	9,996		20	500	500	1,750	56
57	Vinyl Tile Replacement	2008	4,495		20	225	225	900	57
58	Sidwalk Marquee	2008	4,985		10	499	499	1,746	58
59	Generator Repair	2008	2,562		10	256	256	896	59
60	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	2,534	60
61	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	2,303	61
62	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	4,438	62
63	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	1,890	63
64	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	3,647	64
65	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	5,229	65
66	Tiling for Bathroom	2009	13,519		15	902	902	2,255	66
67	Generator Repair	2009	3,984		7	570	570	1,425	67
68	Air Conditioner-Rooftop	2009	10,281		15	686	686	1,715	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,133,234	\$		\$ 93,692	\$ 93,735	\$ 2,228,675	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,133,234	\$		\$ 93,692	\$ 93,692	\$ 2,228,675	1
2	Wandering Patient Alarm System	2010	5,050		7	722	722	1,083	2
3	Sprinkler System Repair	2010	33,658		10	3,366	3,366	5,049	3
4	Water Heater	2011	3,356		7	240	240	240	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16	Land Improvements Booked			1,517			(1,517)		16
17	Building Booked			120,832			(120,832)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,175,298	\$ 122,349		\$ 98,020	\$ (24,329)	\$ 2,235,047	34

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

XI. OWNERSHIP COSTS (continued)

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	\$ 1,020,514	\$ 53,303	\$ 48,077	\$ (5,226)	3-15 yrs.	\$ 819,772	71
72	Current Year Purchases	6,166	707	308	(399)	10 yrs.	308	72
73	Fully Depreciated Assets	58,744					58,744	73
74	Home Office Allocation							74
75	TOTALS	\$ 1,085,424	\$ 54,010	\$ 48,385	\$ (5,625)		\$ 878,824	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				\$	\$	\$			\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	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)	\$ 4,274,222	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,359	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,405	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,954)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,113,871	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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: \$ 14,641
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Care	2010 Ford E350 Van	\$ 1,195	\$ 14,348	17
18					18
19					19
20					20
21	TOTAL		\$ 1,195.00	\$ 14,348	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Prairie Rose Health Care Center

0045245

Period Beginning

Period End

1/1/2011

12/31/2011

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	8,204
Dishwasher		708
Laundry Equipment		-
Copier		<u>5,729</u>
		<u>14,641</u>

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	10A(3)	hrs	\$	4,849	\$ 72,742	\$	4,849	\$ 72,742	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,352	20,278		1,352	20,278	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,142	92,130	52	6,142	92,182	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				65,781		65,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(1)	8914 hrs		179,794			8,914	179,794	13
14	TOTAL			\$ 179,794	12,343	\$ 185,150	\$ 65,833	21,257	\$ 430,777	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 900	\$ 900	1
2	Cash-Patient Deposits	50,288	50,288	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 160,000)	1,051,636	1,051,636	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,576	34,576	6
7	Other Prepaid Expenses	13,727	13,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	4,000	4,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,155,127	\$ 1,155,127	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,415	13,500	13
14	Buildings, at Historical Cost	2,842,209	1,068,665	14
15	Leasehold Improvements, at Historical Cost	225,082	2,106,633	15
16	Equipment, at Historical Cost	1,180,421	1,085,424	16
17	Accumulated Depreciation (book methods)	(2,900,913)	(3,113,871)	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 (spe <u>Loan Costs</u>	312,854	312,854	22
23	Other(specify): <u>See Schedule 17A</u>	296,115	296,115	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,010,183	\$ 1,769,320	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,165,310	\$ 2,924,447	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,206,779	\$ 1,206,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,210	134,210	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,371	16,371	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	215,296	215,296	36
37	<u>Due to Tutura</u>	458,743	458,743	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,031,399	\$ 2,031,399	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,183,582	3,183,582	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Manager</u>	351,000	351,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,534,582	\$ 3,534,582	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,565,981	\$ 5,565,981	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,400,671)	\$ (2,641,534)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,165,310	\$ 2,924,447	48

*(See instructions.)

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 17A

XV. Balance Sheet
 Long Term Assets
 Line 23 - Other Long-Term Assets

	Operating	After Consolidation
Replacement & Reserve Fund	245,619	245,619
Real Estate Tax Escrow	70	70
Repair and Maintenance Reserve	-	-
MIP Reserve	13,873	13,873
Property Insurance Escrow	36,553	36,553
Total Line 23 Other Long-Term Assets	296,115	296,115

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,907,441)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,907,437)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(493,234)	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)	\$ (493,234)	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)	\$ (2,400,671)	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	\$ 3,455,401	1
2	Discounts and Allowances for all Levels	(153,839)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,301,562	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	298,292	6
7	Oxygen	2,893	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 301,185	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,393	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	106,681	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	46,478	20
21	Other Medical Services	11,275	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 172,827	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	288	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 288	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,325	28
28a	Transportation Revenue	470	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,795	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,777,657	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	664,570	31
32	Health Care	1,922,290	32
33	General Administration	874,866	33
	B. Capital Expense		
34	Ownership	419,026	34
	C. Ancillary Expense		
35	Special Cost Centers	332,651	35
36	Provider Participation Fee	57,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,270,891	40
41	Income before Income Taxes (line 30 minus line 40)**	(493,234)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (493,234)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Facility is part of larger entity.

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

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

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	1,876	1,980	\$ 53,362	\$ 26.95	1
2	Assistant Director of Nursing	1,478	1,494	27,159	18.18	2
3	Registered Nurses	5,299	5,747	131,009	22.80	3
4	Licensed Practical Nurses	22,748	24,109	421,437	17.48	4
5	CNAs & Orderlies	60,643	63,645	666,248	10.47	5
6	CNA Trainees					6
7	Licensed Therapist	8,544	8,914	179,794	20.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,026	2,074	20,395	9.83	9
10	Activity Assistants	677	691	6,192	8.96	10
11	Social Service Workers	1,882	2,098	34,485	16.44	11
12	Dietician					12
13	Food Service Supervisor	1,456	1,456	16,027	11.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,684	12,642	113,169	8.95	15
16	Dishwashers					16
17	Maintenance Workers	2,099	2,123	32,617	15.36	17
18	Housekeepers	12,691	13,196	129,934	9.85	18
19	Laundry	1,823	1,962	16,729	8.53	19
20	Administrator	2,080	2,080	43,754	21.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	6,512	6,652	150,919	22.69	33
34	TOTAL (lines 1 - 33)	143,518	150,863	\$ 2,043,230 *	\$ 13.54	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		\$		35
36	Medical Director	Monthly	21,750	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,725	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,475		49

C. CONTRACT NURSES

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

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

** See instructions.

Prairie Rose Health Care Center

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,592	1,664	40,043	24.06
Transportation	325	325	3,503	10.78
Marketing	4,595	4,663	107,373	23.03
TOTAL	6,512	6,652	150,919	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Laura Morrell	Administrator	0	\$ 43,754	Workers' Compensation Insurance		\$ 32,724	IDPH License Fee	\$ 2,750	
				Unemployment Compensation Insurance		29,147	Advertising: Employee Recruitment	361	
				FICA Taxes		140,948	Health Care Worker Background Check		
				Employee Health Insurance		254,409	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	69 696	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	633	
				Employee Relations		1,767	Miscellaneous Dues & Subscriptions	340	
				Employee Retirement		1,774	M.E.S. Dues	2,500	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									

*** 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? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,115 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. N/A

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 57,488
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? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,393

(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. \$ 470

c. What percent of all travel expense relates to transportation of nurses and patients? N/A

d. Have vehicle usage logs been maintained? Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.