

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Mike Kocher Telephone Number: (309) 689-5850
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 1/1/2012 to 12/31/2012 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) Mark B. Petersen
(Title) Chief Executive Officer

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 Rose Health Care Center# 0045245 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 bedsN/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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,379</u>	<u>5,695</u>	<u>1,693</u>	<u>25,767</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>18,379</u>	<u>5,695</u>	<u>1,693</u>	<u>25,767</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.23%

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?

YesG. 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

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

1,610Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	132,589	20,384		152,973		152,973		152,973		1
2	Food Purchase		165,363		165,363		165,363	(7,329)	158,034		2
3	Housekeeping	124,740	15,442		140,182		140,182		140,182		3
4	Laundry	18,946	16,301		35,247		35,247		35,247		4
5	Heat and Other Utilities			91,125	91,125		91,125		91,125		5
6	Maintenance	33,128	11,479	42,571	87,178		87,178		87,178		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	309,403	228,969	133,696	672,068		672,068	(7,329)	664,739		8
	B. Health Care and Programs										
9	Medical Director			19,000	19,000		19,000		19,000		9
10	Nursing and Medical Records	1,366,800	142,799	9,382	1,518,981		1,518,981		1,518,981		10
10a	Therapy	191,991		166,446	358,437		358,437		358,437		10a
11	Activities	31,026		316	31,342		31,342	(2,833)	28,509		11
12	Social Services	35,728			35,728		35,728		35,728		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,625,545	142,799	195,144	1,963,488		1,963,488	(2,833)	1,960,655		16
	C. General Administration										
17	Administrative	46,004		241,996	288,000		288,000		288,000		17
18	Directors Fees										18
19	Professional Services			28,020	28,020		28,020		28,020		19
20	Dues, Fees, Subscriptions & Promotions			3,954	3,954		3,954	(120)	3,834		20
21	Clerical & General Office Expenses		5,266	39,208	44,474		44,474	(700)	43,774		21
22	Employee Benefits & Payroll Taxes			253,399	253,399		253,399		253,399		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			18,152	18,152		18,152		18,152		25
26	Insurance-Prop.Liab.Malpractice			53,388	53,388		53,388		53,388		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	46,004	5,266	638,117	689,387		689,387	(820)	688,567		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,980,952	377,034	966,957	3,324,943		3,324,943	(10,982)	3,313,961		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			160,093	160,093		160,093	(27,809)	132,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			207,384	207,384		207,384	(841)	206,543			32
33	Real Estate Taxes			24	24		24	(24)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,047	40,047		40,047		40,047			35
36	Other (specify):*											36
37	TOTAL Ownership			407,548	407,548		407,548	(28,674)	378,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,006		69,006		69,006		69,006			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			303,486	303,486		303,486		303,486			42
43	Other (specify):* Non-allowable Costs	46,508	1,506	121,251	169,265		169,265	(169,265)				43
44	TOTAL Special Cost Centers	46,508	70,512	424,737	541,757		541,757	(169,265)	372,492			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,027,460	447,546	1,799,242	4,274,248		4,274,248	(208,921)	4,065,327			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,329)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,201)	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	(27,809)	30		9
10	Interest and Other Investment Income	(841)	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	(64,489)	43		18
19	Entertainment				19
20	Contributions	(125)	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	(35,024)	43		24
25	Fund Raising, Advertising and Promotional	(52,920)	43		25
	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	(19,183)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (208,921)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (208,921)		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

Prairie Rose Health Care CenterID# 0045245Report Period Beginning: 1/1/2012Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (13,020)	43	1
2	X-Rays-Part A	(2,279)	43	2
3	Pet Expense	(207)	43	3
4	Miscellaneous Revenue Offset-Office Supplies	(700)	21	4
5	Offset Transportation Revenue	(2,833)	11	5
6	Disallowed Chamber of Commerce Dues	(120)	20	6
7	Disallowed Real Estate Tax	(24)	33	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
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	(19,183)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,329)	0	0	0	0	0	0	0	0	0	0	(7,329)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,329)	0	0	0	0	0	0	0	0	0	0	(7,329)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,833)	0	0	0	0	0	0	0	0	0	0	(2,833)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,833)	0	0	0	0	0	0	0	0	0	0	(2,833)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(120)	0	0	0	0	0	0	0	0	0	0	(120)	20
21	Clerical & General Office Expenses	(700)	0	0	0	0	0	0	0	0	0	0	(700)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(820)	0	0	0	0	0	0	0	0	0	0	(820)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,982)	0	0	0	0	0	0	0	0	0	0	(10,982)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(27,809)	0	0	0	0	0	0	0	0	0	0	(27,809)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(841)	0	0	0	0	0	0	0	0	0	0	(841)	32
33	Real Estate Taxes	(24)	0	0	0	0	0	0	0	0	0	0	(24)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(28,674)	0	0	0	0	0	0	0	0	0	0	(28,674)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(169,265)	0	0	0	0	0	0	0	0	0	0	(169,265)	43
44	TOTAL Special Cost Centers	(169,265)	0	0	0	0	0	0	0	0	0	0	(169,265)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(208,921)	0	0	0	0	0	0	0	0	0	0	(208,921)	45

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
<u>SJL Health Systems, Inc.</u>	<u>100</u>	<u>South Shore Health Care, LLC</u>	<u>Gary, Indiana</u>	<u>None</u>		

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							\$	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 **1/1/2012**
Period End **12/31/2012**

Schedule 6A-Board of Directors

President

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

Secretary

Thomas Hammerton
3400 W. Brenwick Drive
Peoria, IL 61614

Treasurer

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

Director at Large

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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											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								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: 1/1/2012 Ending: 2/31/2012

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							\$		\$	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	\$ 3,124,665	11/01/35	0.0618	\$ 194,816	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,167.65		\$ 3,580,869	\$ 3,124,665			\$ 194,816	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(841)	11	
12								Amortization of Bond Issuance Cost			12,568	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 11,727	14	
15	TOTALS (line 9+line14)						\$ 3,580,869	\$ 3,124,665			\$ 206,543	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 2011 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.)		2011		\$ 24	2
3. Under or (over) accrual (line 2 minus line 1).				\$ 24	3
4. Real Estate Tax accrual used for 2012 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.				(24)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	43	8
2008	48	9
2009	55	10
2010	49	11
2011	24	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 2011	\$	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.**

2011 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 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	11-25-21-401-010-00	Land	\$ 24.48	\$ 24.48
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 24.48	\$ 24.48

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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	\$ 635,260	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363		30	32,345	32,345	843,673	9
10	1987 Additions			1987	110,922		29	3,825	3,825	95,359	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	1,681	23
24	Curtains			1998	6,102		5			6,102	24
25	Sidewalk & Pad			1999	1,484		15	99	99	1,344	25
26	Divide Receipts on Emergency Generator			1999	2,397		20	120	120	1,619	26
27	Med Room Cabinets and Counter Top			1999	2,008		20	100	100	1,304	27
28	Heat/Cool			2000	1,876		7			1,876	28
29	Door Alarms			2001	1,215		15	81	81	864	29
30	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	36,417	30
31	Wooded Doors			2001	1,900		15	127	127	1,406	31
32	Landscaping-Renovation Project			2001	1,174		10			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:

1/1/2012

Ending:

12/31/2012

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	
	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	\$ 1,372	37
38	Therapy Room Remodel	2002	5,617		20	281	281	2,950	38
39	Remodel Medication/Utility Rooms	2002	7,909		20	395	395	4,150	39
40	2 Heating/Cooling Roof Top Units	2002	11,300		10	659	659	11,300	40
41	Breakroom Remodel	2002	3,106		10	180	180	3,106	41
42	Exterior Window Covering	2002	7,650		7			7,650	42
43	Lights for Therapy Room	2002	805		10	71	71	805	43
44	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	18,574	44
45	Fire Supression System	2004	1,540		10	154	154	1,245	45
46	Antenna	2004	2,944		10	294	294	2,598	46
47	Sign	2004	1,200		10	120	120	960	47
48	Carpet	2005	1,281		5			1,281	48
49	Sidewalks	2006	8,735		10	874	874	5,711	49
50	Duct Work	2007	5,120		15	342	342	1,881	50
51	Water Heater	2007	5,378		10	538	538	2,959	51
52	Sidewalks	2007	8,976		15	598	598	3,289	52
53	Water Heater & Duct Work	2008	4,850		10	485	485	2,183	53
54	Air Conditioner-Rooftop	2008	9,120		10	912	912	4,104	54
55	Plumbing Repair	2008	3,442		10	344	344	1,720	55
56	Ceramic Tile Replacement	2008	9,996		20	500	500	2,250	56
57	Vinyl Tile Replacement	2008	4,495		20	225	225	1,125	57
58	Sidwalk Marquee	2008	4,985		10	499	499	2,245	58
59	Generator Repair	2008	2,562		10	256	256	1,152	59
60	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	3,258	60
61	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	2,961	61
62	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	5,706	62
63	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	2,430	63
64	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	4,689	64
65	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	6,723	65
66	Tiling for Bathroom	2009	13,519		15	902	902	3,157	66
67	Generator Repair	2009	3,984		7	570	570	1,995	67
68	Air Conditioner-Rooftop	2009	10,281		15	686	686	2,401	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,133,234	\$		\$ 93,159	\$ 93,159	\$ 2,321,834	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,133,234	\$		\$ 93,159	\$ 93,159	\$ 2,321,834	1
2	Wandering Patient Alarm System	2010	5,050		7	722	722	1,805	2
3	Sprinkler System Repair	2010	33,658		10	3,366	3,366	8,415	3
4	Water Heater	2011	3,356		7	480	480	720	4
5	Fire Alarm Control Installation	2012	2,958		7	211	211	211	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	Land Improvements Booked			1,472			(1,472)		26
27	Building Booked			101,465			(101,465)		27
28	Building Improvements Booked			16,288			(16,288)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,178,256	\$ 119,225		\$ 97,938	\$ (21,287)	\$ 2,332,985	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	\$ 337,086	\$ 40,316	\$ 33,709	\$ (6,607)	10 yrs.	\$ 164,195	71
72	Current Year Purchases	12,739	552	637	85	10 yrs.	637	72
73	Fully Depreciated Assets	748,338					748,338	73
74	Home Office Allocation							74
75	TOTALS	\$ 1,098,163	\$ 40,868	\$ 34,346	\$ (6,522)		\$ 913,170	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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,289,919	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,284	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (27,809)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,246,155	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	N/A				87
88					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

**

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: \$ 25,699
- 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		\$ #####	\$ 14,348	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

Fiscal Year Ending Annual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

* 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 1/1/2012
Period End 12/31/2012

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$ 19,473
Dishwasher	731
Laundry Equipment	-
Copier	5,495
Home Office Allocation	-
	<u>25,699</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

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

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		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	\$	4,358	\$ 65,378	\$	4,358	\$ 65,378	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		616	9,237		616	9,237	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,122	91,831		6,122	91,831	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				69,006		69,006	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)	8775 hrs	191,991				8,775	191,991	13
14	TOTAL			\$ 191,991	11,096	\$ 166,446	\$ 69,006	19,871	\$ 427,443	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 53,869	\$ 53,869	1
2	Cash-Patient Deposits	50,288	50,288	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 160,000)	1,126,235	1,126,235	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,798	37,798	6
7	Other Prepaid Expenses	13,727	13,727	7
8	Accounts Receivable (A/R Prior Owner)	75,941	75,941	8
9	Other(specify): <u>Employee Advances</u>	3,750	3,750	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,361,608	\$ 1,361,608	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	228,040	2,109,591	15
16	Equipment, at Historical Cost	1,193,160	1,098,163	16
17	Accumulated Depreciation (book methods)	(3,061,007)	(3,246,155)	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 (spec <u>Loan Costs</u>	290,286	290,286	22
23	Other(specify): <u>Escrows and Reserves</u>	307,129	307,129	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,854,232	\$ 1,641,179	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,215,840	\$ 3,002,787	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,073,238	\$ 1,073,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,349	132,349	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,092	16,092	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	556,242	556,242	36
37	<u>Due to Tutura</u>	458,743	458,743	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,236,664	\$ 2,236,664	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,124,665	3,124,665	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	351,000	351,000	43
44	<u>Accrued Management Fees</u>	223,753	223,753	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,699,418	\$ 3,699,418	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,936,082	\$ 5,936,082	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,720,242)	\$ (2,933,295)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,215,840	\$ 3,002,787	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,400,671)	1
2	Restatements (describe):		2
3	Prior Year Adj-Nursing Supplies Expense Increase after CR Complete	(9,029)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,409,700)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(310,542)	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)	\$ (310,542)	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)	\$ (2,720,242)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Prairie Rose Health Care Center# 0045245Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 3,684,328	1	
2 Discounts and Allowances for all Levels	(205,379)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,478,949	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	291,823	6	
7 Oxygen	3,213	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,036	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	7,329	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	112,323	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray	38,749	20	
21 Other Medical Services	26,946	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,347	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	841	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 841	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous Revenue	700	28	
28a Transportation Revenue	2,833	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,533	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,963,706	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	672,068	31	
32 Health Care	1,963,488	32	
33 General Administration	689,387	33	
B. Capital Expense			
34 Ownership	407,548	34	
C. Ancillary Expense			
35 Special Cost Centers	238,271	35	
36 Provider Participation Fee	303,486	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,274,248	40	
41 Income before Income Taxes (line 30 minus line 40)**	(310,542)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (310,542)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 2,474,118	44	
45 Private Pay - Net Inpatient Revenue	689,652	45	
46 Medicare - Net Inpatient Revenue	317,777	46	
47 Other-(specify) <u>Charity Therapy Allowance</u>	(2,598)	47	
48 Other-(specify)		48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,478,949	49	

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation.

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

****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	2,080	2,080	\$ 60,575	\$ 29.12	1
2	Assistant Director of Nursing	2,008	2,008	49,371	24.59	2
3	Registered Nurses	3,306	3,510	89,553	25.51	3
4	Licensed Practical Nurses	22,268	23,627	426,310	18.04	4
5	CNAs & Orderlies	62,165	65,107	685,639	10.53	5
6	CNA Trainees					6
7	Licensed Therapist	8,775	9,425	191,991	20.37	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,014	2,060	20,836	10.11	9
10	Activity Assistants	822	827	6,758	8.17	10
11	Social Service Workers	1,957	2,109	35,728	16.94	11
12	Dietician					12
13	Food Service Supervisor	1,816	1,816	18,067	9.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,344	12,806	114,522	8.94	15
16	Dishwashers					16
17	Maintenance Workers	2,061	2,117	33,128	15.65	17
18	Housekeepers	11,828	12,262	124,740	10.17	18
19	Laundry	1,973	2,125	18,946	8.92	19
20	Administrator	2,080	2,080	46,004	22.12	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 PG20A</u>	6,832	7,064	105,292	14.91	33
34	TOTAL (lines 1 - 33)	143,329	151,023	\$ 2,027,460 *	\$ 13.42	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	19,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,076	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)		\$ 24,076		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
0045245
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	2,910	3,078	55,352	17.98
Transportation	316	316	3,432	10.86
Marketing	3,606	3,670	46,508	12.67
TOTAL	6,832	7,064	105,292	

STATE OF ILLINOIS

Facility Name & ID Number

Prairie Rose Health Care Center

0045245

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		Amount
Laura Morrell	Administrator	0	\$ 46,004	Workers' Compensation Insurance		\$ 40,809	IDPH License Fee		\$ 1,990		
				Unemployment Compensation Insurance		38,917	Advertising: Employee Recruitment		694		
				FICA Taxes		145,716	Health Care Worker Background Check				
				Employee Health Insurance		23,651	(Indicate # of checks performed)				
				Employee Meals			Patient Background Checks	79	792		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		343		
				Employee Relations		2,550	Miscellaneous Dues & Subscriptions		135		
				Employee Retirement		1,485					
				Life Insurance		271					
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 46,004								
B. Administrative - Other											
Description			Amount								
Management Fees			\$ 241,996								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 241,996								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Ginoli & Company	Accounting Services		\$ 9,715				Out-of-State Travel		\$		
IL Secretary of State	Title Services		10								
Allscripts	Computer Services		600	N/A							
Danerica Enterprises	Consulting Services		15,000				In-State Travel				
AT&T Services	Computer Services		444								
Consolidated Communications	Computer Services		524								
E-Health Data Solutions	Computer Services		1,539								
Odessian LLC	Legal Services		188				Seminar Expense				
							Home Office Allocation				
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 28,020				line 24, col. 8)	\$			

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. N/A
- (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. \$ 11,458 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. \$ 303,486
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,329
- (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. \$ 2,833
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. \$ _____
- (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 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? No
Attach invoices and a summary of services for all architect and appraisal fees.