FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0036277

Facility Name: Prairie Estates

Address: 403 North State Street (Number) Flora (City) 62839 (Zip Code)

County: Clay

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

HFS ID Number:

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

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 c 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/09 to 09/30/10 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) 01/26/11 (Date)
(Type or Print Name) Terry Elwood
(Title) President

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,566			5,566	13
14	TOTALS	5,566			5,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.31%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/15/90

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 09/30/10 Fiscal Year: 09/30/10

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	43,679	3,078	1,501	48,258		48,258		48,258			1
2	Food Purchase		43,188		43,188	(1,327)	41,861		41,861			2
3	Housekeeping	38,638	4,038		42,676		42,676		42,676			3
4	Laundry	3,011	874		3,885		3,885		3,885			4
5	Heat and Other Utilities			15,216	15,216		15,216	280	15,496			5
6	Maintenance	5,123	1,345	5,964	12,432		12,432		12,432			6
7	Other (specify):*			836	836		836		836			7
8	**TOTAL General Services**	90,451	52,523	23,517	166,491	(1,327)	165,164	280	165,444			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	140,600	781	10,865	152,246	(80)	152,166		152,166			10
10a	Therapy											10a
11	Activities	22,566	63	295	22,924		22,924		22,924			11
12	Social Services	9,800			9,800		9,800		9,800			12
13	CNA Training											13
14	Program Transportation			6,140	6,140	(1,165)	4,975		4,975			14
15	Other (specify):* Hab Aide Training	2,280	50		2,330		2,330		2,330			15
16	**TOTAL Health Care and Programs**	175,246	894	17,300	193,440	(1,245)	192,195		192,195			16
	C. General Administration											
17	Administrative	65,862			65,862	(416)	65,446		65,446			17
18	Directors Fees							2,525	2,525			18
19	Professional Services			91,200	91,200		91,200	1,400	92,600			19
20	Dues, Fees, Subscriptions & Promotions			230	230		230	(50)	180			20
21	Clerical & General Office Expenses	5,423	9,357		14,780		14,780	1,388	16,168			21
22	Employee Benefits & Payroll Taxes			26,654	26,654	1,327	27,981	12,541	40,522			22
23	Inservice Training & Education					496	496		496			23
24	Travel and Seminar			320	320	127	447		447			24
25	Other Admin. Staff Transportation			1,046	1,046	(127)	919	808	1,727			25
26	Insurance-Prop.Liab.Malpractice			5,115	5,115		5,115	175	5,290			26
27	Other (specify):*											27
28	**TOTAL General Administration**	71,285	9,357	124,565	205,207	1,407	206,614	18,787	225,401			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	336,982	62,774	165,382	565,138	(1,165)	563,973	19,067	583,040			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.

Facility Name & ID Number Prairie Estates #0036277 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,931	21,931		21,931	9	21,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							700	700			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	**TOTAL Ownership**			21,931	21,931		21,931	3,109	25,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,165	1,165		1,165			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,692	34,692		34,692		34,692			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			34,692	34,692	1,165	35,857		35,857			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	336,982	62,774	222,005	621,761		621,761	22,176	643,937			45

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50)	L20		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 Annual Report Fee (Home Office)	(5)	L20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55)		$	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	22,231	Pg 6a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 22,231		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 22,176		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 1,165	L14	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			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,165		47

Prairie Estates

ID# 0036277

Report Period Beginning: 10/01/09

Ending: 09/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Estates # 0036277 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Prairie Estates** **#** **0036277** **Report Period Beginning:** **10/01/09** **Ending:** **09/30/10**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See attached 6a	$ 22,231	Marion County Horizon Center	0.00%	$ 44,462	$ 22,231	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			$ 22,231			$ 44,462	$ * 22,231	14

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Terry Elwood	Director	Board Member	0.00	1,275	2	6.00	Director Fee	$ 1,275	L18, C7	1
2	Amanda Miller	Director	Board Member	0.00	625	1	3.00	Director Fee	625	L18, C7	2
3	Julie Quinn	Director	Board Member	0.00	625	1	3.00	Director Fee	625	L18, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,525		13

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

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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 [x] NO [ ]

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

Name of Related Organization: Marion County Horizon Center
Street Address: 122 N Hotze Road
City / State / Zip Code: Salem, IL 62881
Phone Number: (618-548-0309
Fax Number: (618-548-3720

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facilities	2	2	$ 560	$ 0	1	$ 280	1
2	18	Director Fees	Facilities	2	2	5,050	0	1	2,525	2
3	19	Accounting	Facilities	2	2	2,800	0	1	1,400	3
4	20	License Fees	Facilities	2	2	10	0	1	5	4
5	21	Telephone	Facilities	2	2	532	0	1	266	5
6	21	Office Supplies	Facilities	2	2	558	0	1	279	6
7	21	Computer Expense	Facilities	2	2	1,686	0	1	843	7
8	22	W/C Insurance	Facilities	2	2	15,670	0	1	7,835	8
9	22	Emp. Health Ins.	Facilities	2	2	4,166	0	1	2,083	9
10	22	State Unemp. Taxes	Facilities	2	2	5,246	0	1	2,623	10
11	25	Gas & Oil	Facilities	2	2	448	0	1	224	11
12	25	Trans. Rep. & Main.	Facilities	2	2	1,168	0	1	584	12
13	26	Building Insurance	Facilities	2	2	350	0	1	175	13
14	30	Depreciation	Facilities	2	2	18	0	1	9	14
15	34	Other Rent	Facilities	2	2	1,400	0	1	700	15
16	35	Vehicle Rent	Facilities	2	2	4,800	0	1	2,400	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 44,462	$		$ 22,231	25

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ None	$ None			$ None	15

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

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

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

Facility Name & ID Number Prairie Estates # 0036277 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ None	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	None	8
2006	None	9
2007	None	10
2008	None	11
2009	None	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Estates COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0036277

CONTACT PERSON REGARDING THIS REPORT Rita Armbrust

TELEPHONE 618-548-0309 FAX #: 618-548-3720

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ None	$

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,514 B. General Construction Type: Exterior Vinyl Frame Wood & Brick Number of Stories One

C. Does the Operating Entity? [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,092	1991	$ 7,000	1
2					2
3	TOTALS	29,092		$ 7,000	3

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1986	$ 392,196	$ 15,688	25	$ 15,688	$	$ 300,685	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1986	4,294		10			4,294	9
10	Walk & Driveway			1986	2,738		20			2,719	10
11	Decorating			1986	300		5			300	11
12	Carpet & Tile			1987	1,014		6			1,014	12
13	Drapes			1987	770		6			770	13
14	Landscaping			1991	1,111		10			1,111	14
15	Paving/Concrete			1991	11,838	592	20	592		11,346	15
16	Wood Deck			1991	1,174		15			1,174	16
17	Garage			1991	13,672		15			13,672	17
18	Landscaping			1991	2,369		10			2,369	18
19	Flooring			1994	1,721		15			1,721	19
20	Landscaping			1995	1,435		10			1,435	20
21	Vinyl Flooring			1998	3,468	231	15	231		2,869	21
22	Roof replacement (shingles)			2003	8,715	436	20	436		3,125	22
23	Replace Decking & substructure			2003	4,640	232	20	232		1,663	23
24	Bathroom Remodeling			2003	6,845	342	20	342		2,423	24
25	Bathroom tub & shower replaced/remodeled			2004	8,598	430	20	430		2,759	25
26	Remodel Kitchen/cabinets			2005	4,906	327	15	327		1,771	26
27	Cabinets bathroom/laundry			2006	4,948	247	20	247		1,215	27
28	Plumbing kitchen area			2006	2,267	151	15	151		743	28
29	Bathroom Remodeling			2007	24,751	1,238	20	1,238		4,333	29
30	Heating duct repair/replacement			2007	7,649	510	15	510		1,657	30
31	Replace subfloor furnace room			2007	1,535	102	15	102		323	31
32											32
33											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 Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 512,954	$ 20,526		$ 20,526	$	$ 365,491	70

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 50,008	$ 748	$ 748	$	10	$ 49,593	71
72	Current Year Purchases	2,800	90	90		5	90	72
73	Fully Depreciated Assets							73
74	Home Office Equipment	519	9	9		7	9	74
75	TOTALS	$ 53,327	$ 847	$ 847	$		$ 49,692	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Transportation	1999 Dodge Van	1999	$ 23,106	$	$	$	4	$ 23,106	76
77	Used Handicapped Van	1999 Ford Ecoline Sport Van	2010	8,500	567	567		4	567	77
78		(with wheelchair lift)								78
79										79
80	TOTALS			$ 31,606	$ 567	$ 567	$		$ 23,673	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)	$ 604,887	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,940	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,940	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 438,856	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Shivam Hotel, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [x] 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	Office	1987		3/09/92	700			5
6								6
7	TOTAL				$ 700 **			7

10. Effective dates of current rental agreement:
    Beginning 03/09/2009
    Ending 03/09/2014

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

	Fiscal Year Ending	Annual Rent
12.	09/30/2011	$ 4,200
13.	09/30/2012	$ 4,200
14.	09/30/2013	$ 4,200

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 [x] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Transportation	2004 GMC Envoy	$ 200.00	$ 2,400	17
18					18
19					19
20					20
21	TOTAL		$ 200.00	$ 2,400	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.

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] 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	50
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	80
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		50		50
3	Classroom Wages (a)		800		800
4	Clinical Wages (b)		1,280		1,280
5	In-House Trainer Wages (c)		200		200
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,330	$	$ 2,330
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,330			

C. CONTRACTUAL INCOME

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

$ None

D. NUMBER OF CNAs TRAINED

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

(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.

Facility Name & ID Number Prairie Estates

STATE OF ILLINOIS
0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ None		$ None	$ None	None	$ None	14

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

STATE OF ILLINOIS

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/10 (last day of reporting year)

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	$ 405,576	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	134,472		3
4	Supply Inventory (priced at cost)	2,004		4
5	Short-Term Investments	68,927		5
6	Prepaid Insurance	499		6
7	Other Prepaid Expenses	74		7
8	Accounts Receivable (owners or related parties)	53,933		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 665,485	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,000		13
14	Buildings, at Historical Cost	405,868		14
15	Leasehold Improvements, at Historical Cost	107,086		15
16	Equipment, at Historical Cost	75,368		16
17	Accumulated Depreciation (book methods)	(429,757)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 165,565	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 831,050	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,539	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,661		30
31	Accrued Taxes Payable (excluding real estate taxes)	347		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 20,547	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 810,503	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 831,050	$	48

***(See instructions.)**

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 747,891	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 747,891	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	62,612	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)**	$ 62,612	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)**	$ 810,503	24	*

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 617,560	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 617,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,302	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,165	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,467	23
	D. Non-Operating Revenue		
24	Contributions	48,103	24
25	Interest and Other Investment Income***	14,243	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,346	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 684,373	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	166,491	31
32	Health Care	193,440	32
33	General Administration	205,207	33
	B. Capital Expense		
34	Ownership	21,931	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,692	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 621,761	40
41	**Income before Income Taxes (line 30 minus line 40)****	62,612	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 62,612	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,651	1,683	15,536	9.23	9
10	Activity Assistants	948	1,052	7,030	6.68	10
11	Social Service Workers	420	420	9,800	23.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,495	1,543	15,451	10.01	14
15	Cook Helpers/Assistants	2,630	2,894	28,228	9.75	15
16	Dishwashers					16
17	Maintenance Workers	16	16	5,123	320.19	17
18	Housekeepers	3,418	3,522	38,638	10.97	18
19	Laundry	300	312	3,011	9.65	19
20	Administrator	1,200	1,248	35,000	28.04	20
21	Assistant Administrator	1,394	1,490	20,462	13.73	21
22	Other Administrative	400	416	10,400	25.00	22
23	Office Manager					23
24	Clerical	569	593	5,423	9.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	980	1,020	25,000	24.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,454	11,758	115,600	9.83	30
31	Medical Records					31
32	Other Health C: H.A. Trainer	12	12	200	16.67	32
33	Other(specify) H.A. Training	260	260	2,080	8.00	33
34	TOTAL (lines 1 - 33)	27,147	28,239	$ 336,982 *	$ 11.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,501	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	150	3,300	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	990	L10, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	48	3,600	L10, C3	47
48	Psychologist Consultant	39	2,975	L10, C3	48
49	TOTAL (lines 35 - 48)	277	$ 12,366		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	None	$		53

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trena Briscoe, LNHA	Administrator	0%	$ 35,000
Lisa Agee	Asst. Admn.	0%	20,462
Char Watton, LNHA, MSW	Administrative	0%	10,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,862

B. Administrative - Other

Description	Amount
None	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Care Mgmt. Corp.	Admn Consulting Fees	$ 91,200
Krehbiel & Associates	*Accounting	1,400
*Pass thru home office		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 92,600

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,850
Unemployment Compensation Insurance	3,273
FICA Taxes	25,779
Employee Health Insurance	2,083
Employee Meals	1,327
Illinois Municipal Retirement Fund (IMRF)*	
Staff Flu Shots	50
Staff TB Tests	160
Pass thru Home Office:	
W/C Insurance = 7835	
Unemp Insurance = 2623	
Employee Health Ins = 2083	
TOTAL (agree to Schedule V, line 22, col.8)	$ 40,522

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

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	50
Newspaper Subscription	35
16-passenger Van license fee	10
Handicapped van license/title fee	105
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 180

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
CILA Seminar (Springfield) 4/13/10	131
Reg. Updates (Springfield) 6/29/10	127
Seminar Expense	
DD Seminar	90
Aging & Falls	99
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 447

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/09 Ending: 09/30/10

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	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Estates **#** 0036277 **Report Period Beginning:** 10/01/09 **Ending:** 09/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **34,692**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,327** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **1,165**
c. What percent of all travel expense relates to transportation of nurses and patients? **83.90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Reclassification Entries

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

To re-classify free employee meals from food costs to employee benefits.

2	Medially Necessary Transportation, Line 38	$1,165	
	Program Transportation, Line 14		$1,165

To re-classify medical transportation for clients per separate contract w/DPA.

3	In-service Training & Education, Line 23	$496	
	Nursing & Medical Records, Line 10		$80
	Administrative, Line 17		$416

To re-classify in-wervice training fees paid to instructors as follows:
10/01/09 Trena Briscoe--Infection Control
11/09/09 Nichole Perry, R.N. - Incident Report Procedures
12/09/09 Nichole Perry, R.N. - H1N1 Information
01/14/10 Trena Briscoe - Maintenance Log
02/16/10 Trena Briscoe - Fire Safety Evacuation
02/10/10 Lisa Agee - Fall Risk Assessment
02/25/10 Trena Briscoe - Medication Error
03/10/10 Trena Briscoe - Clinical Signs of Aspiration
3/23/10 Lisa Agee - Van Mileage and Van rules
5/10/10 Lisa Agee - Storage Closet
5/28/10 Lisa Agee - Diet Modification
05/10/10 Trena Briscoe - Hot Weather
06/10/10 Trena Briscoe - New client information packet
06/10/10 Trena Briscoe - Resident Rights Prevention of abuse/neglect
07/10/10 Trena Briscoe - Fall Prevention
07/26/10 Trena Briscoe - Serotonin syndrome signs and symptoms
8/9/10 Trena Briscoe - Cervical Cancer Signs & Symptoms
9/9/10 Trena Briscoe - Stroke Signs and Symptoms

4	Travel & Seminar, Line 24	$127	
	Other Admn. Staff Transportation, Line 25		$127

To re-classify seminar mileage on 6/29/10.

Statement of Compensation

	#0036277 Prairie Estates	#0036285 Richland Manor	Total
Terry Elwood	$1,275	$1,275	$2,550
Amanda Miller	$625	$625	$1,250
Julie Quinn	$625	$625	$1,250
Totals	$2,525	$2,525	$5,050

Related Expense Allocation of Marion County Horizon Center

Schedule V Line Reference	Item	Total Marion County Horizon Center Expenses	% of Ownership	Allocation Prairie Estates	Allocation Richland Manor
5	Utilities	$560	0%	$280	$280
18	Director Fees	$5,050	0%	$2,525	$2,525
19	Accounting	$2,800	0%	$1,400	$1,400
20	License fees	$10	0%	$5	$5
21	Telephone	$532	0%	$266	$266
21	Office Supplies	$558	0%	$279	$279
21	Computer Expense	$1,686	0%	$843	$843
22	W/C Insurance	$15,670	0%	$7,835	$7,835
22	Emp. Health Ins.	$4,166	0%	$2,083	$2,083
22	State Unemp Taxes	$5,246	0%	$2,623	$2,623
25	Gas & Oil	$448	0%	$224	$224
25	Trans. Rep & Main.	$1,168	0%	$584	$584
26	Building Insurance	$350	0%	$175	$175
30	Depreciation	$18	0%	$9	$9
34	Other Rent	$1,400	0%	$700	$700
35	Vehicle Rent	$4,800	0%	$2,400	$2,400
		$44,462		$22,231	$22,231

Prairie Estates #0036277 09/30/10

Care Related Assets

	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Component Life	Accm. Depreciation
Equipment (Purchased in Prior Years)						
Home Office	27,134	$0			7	
% Home Office Allocated	x.333	x.5				
	$9,045	$0	$0			$9,089
Prairie Estates Equipment	$40,963	$748	$748	0	7	$40,504
Total XI-C, Line 71	$50,008	$748	$748	0		$49,593
Equipment (Current Year Purchases)						
Home Office	$1,037	$17	$17		7	
% of Home Office Allocated	x.5	x.5	x.5			
	$519	$9	$9	0		$9
Prairie Estates Equipment	$2,800	$90	$90	0	4	$90
Total XI-C, Line 72 + Line 74	$3,319	$99	$99			$99

Other Administrative Transportation (Line 25, Column 8)

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

Total miles reimbursed -- 2042 miles x $.45/mile	$919
Repair, maintenance, gas and oil for vans (from Home Office)	$808
Total	$1,727

Breakdown of Individual Salary Costs

Trena Briscoe's pay has been allocated as follows:

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

Charlotte Watton's hours have been allocated as follows:

Social Services -1/2 salary
Administrative - 1/2 salary