FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 South Chestnut Street (Number) Pana (City) 62557 (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:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 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: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 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	105	Skilled (SNF)	105	38,325	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	105	TOTALS	105	38,325	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	19,111	5,331	2,651	27,093	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,111	5,331	2,651	27,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

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

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

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

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

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

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 [X] Date 3/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 2,599

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	128,619	19,189		147,808		147,808		147,808			1
2	Food Purchase		140,559		140,559		140,559	(9,150)	131,409			2
3	Housekeeping	130,849	16,630		147,479		147,479		147,479			3
4	Laundry	16,821	15,163		31,984		31,984		31,984			4
5	Heat and Other Utilities			124,535	124,535		124,535		124,535			5
6	Maintenance	23,263	5,018	27,419	55,700		55,700		55,700			6
7	Other (specify):*											7
8	TOTAL General Services	299,552	196,559	151,954	648,065		648,065	(9,150)	638,915			8
	B. Health Care and Programs											
9	Medical Director			21,500	21,500		21,500		21,500			9
10	Nursing and Medical Records	1,339,598	121,081	3,637	1,464,316		1,464,316	(80)	1,464,236			10
10a	Therapy	180,776	147	245,812	426,735		426,735		426,735			10a
11	Activities	26,693	292	317	27,302		27,302		27,302			11
12	Social Services	33,759			33,759		33,759		33,759			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,580,826	121,520	271,266	1,973,612		1,973,612	(80)	1,973,532			16
	C. General Administration											
17	Administrative	43,754		255,246	299,000		299,000		299,000			17
18	Directors Fees											18
19	Professional Services			20,566	20,566		20,566		20,566			19
20	Dues, Fees, Subscriptions & Promotions			14,915	14,915		14,915		14,915			20
21	Clerical & General Office Expenses	23,355	10,485	33,269	67,109		67,109	(390)	66,719			21
22	Employee Benefits & Payroll Taxes			444,227	444,227		444,227		444,227			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,233	9,233		9,233		9,233			25
26	Insurance-Prop.Liab.Malpractice			56,485	56,485		56,485		56,485			26
27	Other (specify):*											27
28	TOTAL General Administration	67,109	10,485	833,941	911,535		911,535	(390)	911,145			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,947,487	328,564	1,257,161	3,533,212		3,533,212	(9,620)	3,523,592			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 Rose Health Care Center #0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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			170,914	170,914		170,914	(28,865)	142,049			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,249	214,249		214,249	(1,193)	213,056			32
33	Real Estate Taxes			55	55		55	(55)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,402	24,402		24,402		24,402			35
36	Other (specify):*											36
37	TOTAL Ownership			409,620	409,620		409,620	(30,113)	379,507			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,493		85,493		85,493		85,493			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,488	57,488		57,488		57,488			42
43	Other (specify):* Non-allowable Cost	40,699	1,735	75,748	118,182		118,182	(118,182)				43
44	TOTAL Special Cost Centers	40,699	87,228	133,236	261,163		261,163	(118,182)	142,981			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,988,186	415,792	1,800,017	4,203,995		4,203,995	(157,915)	4,046,080			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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,150)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,102)	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	(28,865)	30		9
10	Interest and Other Investment Income	(1,193)	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	(14,362)	43		18
19	Entertainment				19
20	Contributions	(2,408)	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	(14,844)	43		24
25	Fund Raising, Advertising and Promotional	(7,884)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(78,107)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (157,915)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (157,915)		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 Center

ID# 0045245

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (33,836)	43	1
2	X-Rays-Part A	(2,135)	43	2
3	Pet Expense	(957)	43	3
4	Special Events	140	43	4
5	Miscellaneous Revenue Offset-Office Supplies	(390)	21	5
6	Miscellaneous Revenue Offset-Nursing Supplies	(80)	10	6
7	Disallowed Marketing Salaries	(40,699)	43	7
8	Disallowed R.E. Taxes	(55)	33	8
9	Resident Flowers	(95)	43	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**	(78,107)		49

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

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

1 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						$	$	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 1/1/2010
Period End 12/31/2010

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: 1/1/2010 Ending: 12/31/2010

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	N/A										1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X]

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 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						$	$		$	1
2										2
3										3
4										4
5		N/A								5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	Wells Fargo		X	Mortgage	$21,167.65	12/01/02	$ 3,580,869	$ 3,238,977	11/01/35	0.0618	$ 201,682	1
2												2
3							Interest Income Offset				(1,193)	3
4							Amortization of Bond Issuance Cost				12,567	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,167.65		$ 3,580,869	$ 3,238,977			$ 213,056	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 3,238,977			$ 213,056	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 16,314 **Line #** 26

*** 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 Rose Health Care Center # 0045245 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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.)	**2009**	$ 55	2
3. Under or (over) accrual (line 2 minus line 1).		$ 55	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. **Disallowed R.E. Taxes**		$ (55)	
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:		
	2005	8
	2006	9
	2007 43	10
	2008 48	11
	2009 55	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 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 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 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.	11-25-21-401-010-00	Land	$ 54.95	$ 54.95
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54.95	$ 54.95

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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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? [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. [X] (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 [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	28,000	1995	$ 13,500	1
2					2
3	TOTALS	28,000		$ 13,500	3

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	121		1995	1976	$ 1,068,665	$	30	$ 35,622	$ 35,622	$ 564,016	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363		30	32,345	32,345	778,983	9
10	1987 Additions			1987	110,922		29	3,825	3,825	87,709	10
11	1989 Additions			1989	2,219		10			2,219	11
12	1990 Additions			1990	4,295		30	25	25	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	557	557	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	1,445	23
24	Curtains			1998	6,102		5			6,102	24
25	Sidewalk & Pad			1999	1,484		15	99	99	1,146	25
26	Divide Receipts on Emergency Generator			1999	2,397		20	120	120	1,379	26
27	Med Room Cabinets and Counter Top			1999	2,008		20	100	100	1,104	27
28	Heat/Cool			2000	1,876		7			1,876	28
29	Door Alarms			2001	1,215		15	81	81	702	29
30	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	30,129	30
31	Wooded Doors			2001	1,900		15	127	127	1,152	31
32	Landscaping-Renovation Project			2001	1,174		10	117	117	1,253	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: 1/1/2010 Ending: 12/31/2010

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	Replace Plumbing Fixtures	2002	$ 2,490	$	20	$ 125	125	1,122	37
38	Therapy Room Remodel	2002	5,617		20	281	281	2,388	38
39	Remodel Medication/Utility Rooms	2002	7,909		20	395	395	3,360	39
40	2 Heating/Cooling Roof Top Units	2002	11,300		10	1,130	1,130	9,511	40
41	Breakroom Remodel	2002	3,106		10	311	311	2,615	41
42	Exterior Window Covering	2002	7,650		7			7,650	42
43	Lights for Therapy Room	2002	805		10	81	81	653	43
44	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	14,890	44
45	Fire Supression System	2004	1,540		10	154	154	937	45
46	Antenna	2004	2,944		10	294	294	2,010	46
47	Sign	2004	1,200		10	120	120	720	47
48	Carpet	2005	1,281		5	43	43	1,281	48
49	Sidewalks	2006	8,735		10	874	874	3,963	49
50	Duct Work	2007	5,120		15	342	342	1,197	50
51	Water Heater	2007	5,378		10	538	538	1,883	51
52	Sidewalks	2007	8,976		15	598	598	2,093	52
53	Water Heater & Duct Work	2008	4,850		10	485	485	1,213	53
54	Air Conditioner-Rooftop	2008	9,120		10	912	912	2,280	54
55	Plumbing Repair	2008	3,442		10	344	344	1,032	55
56	Ceramic Tile Replacement	2008	9,996		20	500	500	1,250	56
57	Vinyl Tile Replacement	2008	4,495		20	225	225	675	57
58	Sidwalk Marquee	2008	4,985		10	499	499	1,247	58
59	Generator Repair	2008	2,562		10	256	256	640	59
60	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	1,810	60
61	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	1,645	61
62	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	3,170	62
63	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	1,350	63
64	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	2,605	64
65	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	3,735	65
66	Tiling for Bathroom	2009	13,519		15	902	902	1,353	66
67	Generator Repair	2009	3,984		7	570	570	855	67
68	Air Conditioner-Rooftop	2009	10,281		15	686	686	1,029	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,133,234	$		$ 94,513	$ 94,513	$ 2,134,983	70

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	
1	Totals from Page 12A, Carried Forward		$ 3,133,234	$		$ 94,513	$ 94,513	$ 2,134,983	1
2	Wandering Patient Alarm System	2010	5,050		7	361	361	361	2
3	Sprinkler System Repair	2010	33,658		10	1,683	1,683	1,683	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	Land Improvements Booked			1,562			(1,562)		16
17	Building Booked			35,622			(35,622)		17
18	Building Improvement Booked			82,516			(82,516)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,171,942	$ 119,700		$ 96,557	$ (23,143)	$ 2,137,027	34

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 966,122	$ 40,587	$ 42,772	$ 2,185	3-15 yrs.	$ 768,975	71
72	Current Year Purchases	54,392	10,627	2,720	(7,907)	10 yrs.	2,720	72
73	Fully Depreciated Assets	58,744					58,744	73
74	Home Office Allocation							74
75	TOTALS	$ 1,079,258	$ 51,214	$ 45,492	$ (5,722)		$ 830,439	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										76
77										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)	$ 4,264,700	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,914	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,049	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (28,865)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,967,466	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 12,445 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	$ 11,957	17
18					18
19					19
20					20
21	TOTAL		$ 1,195	$ 11,957	21

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

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

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 14A

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

Medical Equipment	$	9,409
Dishwasher		708
Copier		2,328
		12,445

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

Facility Name & ID Number Prairie Rose Health Care Center

STATE OF ILLINOIS
0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,862	$ 102,930	$	6,862	$ 102,930	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,146	17,198		1,146	17,198	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,378	125,684	147	8,378	125,831	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				85,493		85,493	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)	9379 hours	180,776				9,379	180,776	13
14	TOTAL			$ 180,776	16,386	$ 245,812	$ 85,640	25,765	$ 512,228	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 Rose Health Care Center # 0045245 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 276,696	$ 276,696	1
2	Cash-Patient Deposits	48,719	48,719	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	371,275	371,275	3
4	Supply Inventory (priced at Cost)	13,727	13,727	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,339	29,339	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 739,756	$ 739,756	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	221,726	2,103,277	15
16	Equipment, at Historical Cost	1,174,256	1,079,258	16
17	Accumulated Depreciation (book methods)	(2,724,556)	(2,967,466)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Loan Costs**	312,272	312,272	22
23	Other(specify): See Schedule 17A	378,591	378,591	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,258,913	$ 1,988,097	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,998,669	$ 2,727,853	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 656,051	$ 656,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,776	137,776	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,681	16,681	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	46,882	46,882	36
37	Due to Tutera	458,743	458,743	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,316,133	$ 1,316,133	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,238,977	3,238,977	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Manager	351,000	351,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,589,977	$ 3,589,977	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,906,110	$ 4,906,110	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,907,441)	$ (2,178,257)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,998,669	$ 2,727,853	48

***(See instructions.)**

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 17A

XV. Balance Sheet

Long Term Assets

Line 23 - Other Long-Term Assets

	Operating	After Consolidation
Replacement & Reserve Fund	91,800	91,800
Real Estate Tax Escrow	18	18
Repair and Maintenance Reserve	240,106	240,106
MIP Reserve	14,429	14,429
Property Insurance Escrow	32,238	32,238
Total Line 23 Other Long-Term Assets	378,591	378,591

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,886,922)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,886,922)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,519)	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)**	$ (20,519)	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)**	$ (1,907,441)	24 *

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 3,877,361	1
2	Discounts and Allowances for all Levels	(352,755)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,524,606	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	377,936	6
7	Oxygen	3,685	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 381,621	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	9,150	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	154,765	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	79,349	20
21	Other Medical Services	31,722	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 274,986	23
	D. Non-Operating Revenue		
24	Contributions	600	24
25	Interest and Other Investment Income***	1,193	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,793	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	470	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 470	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,183,476	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	648,065	31
32	Health Care	1,973,612	32
33	General Administration	911,535	33
	B. Capital Expense		
34	Ownership	409,620	34
	C. Ancillary Expense		
35	Special Cost Centers	203,675	35
36	Provider Participation Fee	57,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,203,995	40
41	**Income before Income Taxes (line 30 minus line 40)****	(20,519)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (20,519)	43

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

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	2,080	2,080	$ 54,909	$ 26.40	1
2	Assistant Director of Nursing	1,121	1,121	18,485	16.49	2
3	Registered Nurses	5,996	6,279	141,750	22.58	3
4	Licensed Practical Nurses	22,873	24,143	403,713	16.72	4
5	CNAs & Orderlies	62,815	65,541	682,237	10.41	5
6	CNA Trainees					6
7	Licensed Therapist	8,677	9,379	180,776	19.27	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,052	2,100	20,102	9.57	9
10	Activity Assistants	706	721	6,038	8.37	10
11	Social Service Workers	1,859	2,115	33,759	15.96	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	21,810	10.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,673	12,357	106,809	8.64	15
16	Dishwashers					16
17	Maintenance Workers	1,752	1,756	23,263	13.25	17
18	Housekeepers	13,375	13,850	130,849	9.45	18
19	Laundry	1,819	1,984	16,821	8.48	19
20	Administrator	2,080	2,080	43,754	21.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,403	1,427	23,355	16.37	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 C: CPC	2,080	2,080	38,504	18.51	32
33	Other(specify) See Sch 20A	2,906	2,906	41,252	14.20	33
34	TOTAL (lines 1 - 33)	147,347	153,999	$ 1,988,186 *	$ 12.91	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		$		35
36	Medical Director	Monthly	21,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,330	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,830		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Prairie Rose Health Care Center

Period Beginning **1/1/2010**
Period End **12/31/2010**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation	54	54	553	10.24
Marketing	2,852	2,852	40,699	14.27
TOTAL	2,906	2,906	41,252	

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Morrell	Administrator	0	$ 43,754
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,754

B. Administrative - Other

Description	Amount
Management Fees	$ 255,246
TOTAL (agree to Schedule V, line 17, col. 3)	$ 255,246
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ginoli & Company	Accounting Services	$ 13,985
Consolidated Communications	Computer Services	349
Mike Kuhl	Director's Fees	1,500
Medallion Services	Design Services	500
AT & T	Computer Services	381
E-Health Data Solutions	Computer Services	3,701
Registered Agent Solutions	Legal Services	150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 20,566

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,866
Unemployment Compensation Insurance	840
FICA Taxes	142,250
Employee Health Insurance	238,084
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	15,593
Employee Retirement	1,594
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,227

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	88
Health Care Worker Background Check	
(Indicate # of checks performed 123)	
Patient Background Checks	1,234
Miscellaneous Licenses & Permits	498
Miscellaneous Dues & Subscriptions	15
IHCA Dues	6,600
M.E.S. Dues	2,500
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,915

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

**See instructions.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **6,600 IHCA**

(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. $ **13,302** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **57,488**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,150**

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

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

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