FOR BHF USE

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

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

I. IDPH License ID Number: 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 10/01/11 to 09/30/12 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) 01/30/13 (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: 10/01/11 Ending: 09/30/12

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	5,856	6
7	16	TOTALS	16	5,856	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	5,191			5,191	13
14	TOTALS	5,191			5,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.64%

D. How many bed-hold days during this year were paid by the Department?
97 (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 07/31/91 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 [ ] NO [ ]

Tax Year: 09/30/12 Fiscal Year: 09/30/12

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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	44,001	4,486	1,385	49,872		49,872		49,872			1
2	Food Purchase		39,440		39,440	(1,327)	38,113	313	38,426			2
3	Housekeeping	29,861	6,460		36,321		36,321	4	36,325			3
4	Laundry		1,636		1,636		1,636		1,636			4
5	Heat and Other Utilities			14,146	14,146		14,146	1,540	15,686			5
6	Maintenance	4,651	2,618	8,136	15,405		15,405	482	15,887			6
7	Other (specify):* Garbage Pickup			852	852		852	12	864			7
8	TOTAL General Services	78,513	54,640	24,519	157,672	(1,327)	156,345	2,351	158,696			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	174,195	2,643	13,054	189,892		189,892		189,892			10
10a	Therapy											10a
11	Activities	20,916	6	83	21,005		21,005		21,005			11
12	Social Services	3,000			3,000		3,000		3,000			12
13	CNA Training											13
14	Program Transportation			6,049	6,049	(1,144)	4,905		4,905			14
15	Other (specify):* H.A.Training	902	21	44	967		967		967			15
16	TOTAL Health Care and Programs	199,013	2,670	19,230	220,913	(1,144)	219,769		219,769			16
	C. General Administration											
17	Administrative	57,530			57,530		57,530	15,000	72,530			17
18	Directors Fees							2,250	2,250			18
19	Professional Services			91,200	91,200		91,200	1,558	92,758			19
20	Dues, Fees, Subscriptions & Promotions			412	412		412	527	939			20
21	Clerical & General Office Expenses	6,987	6,933		13,920		13,920	5,180	19,100			21
22	Employee Benefits & Payroll Taxes			26,439	26,439	1,327	27,766	12,236	40,002			22
23	Inservice Training & Education			24	24		24		24			23
24	Travel and Seminar			553	553	194	747		747			24
25	Other Admin. Staff Transportation			1,021	1,021	(50)	971	1,688	2,659			25
26	Insurance-Prop.Liab.Malpractice			17	17		17	6,700	6,717			26
27	Other (specify):*											27
28	TOTAL General Administration	64,517	6,933	119,666	191,116	1,471	192,587	45,139	237,726			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	342,043	64,243	163,415	569,701	(1,000)	568,701	47,490	616,191			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:** 10/01/11 **Ending:** 09/30/12

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			23,803	23,803		23,803	875	24,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,200	4,200			34
35	Rent-Equipment & Vehicles							2,400	2,400			35
36	Other (specify):*											36
37	**TOTAL Ownership**			23,803	23,803		23,803	7,475	31,278			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,000	1,000		1,000			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,063	37,063		37,063		37,063			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			37,063	37,063	1,000	38,063		38,063			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	342,043	64,243	224,281	630,567		630,567	54,965	685,532			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: 10/01/11 Ending: 09/30/12

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)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	55,015	VII B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,015		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 54,965		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		$ 1,000	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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,000		47

Prairie Estates

ID# 0036277

Report Period Beginning: 10/01/11

Ending: 09/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	None	$		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:** 10/01/11 **Ending:** 09/30/12

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	313	0	0	0	0	0	0	0	0	0	313	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,540	0	0	0	0	0	0	0	0	0	1,540	5
6	Maintenance	0	482	0	0	0	0	0	0	0	0	0	482	6
7	Other (specify):*	0	12	0	0	0	0	0	0	0	0	0	12	7
8	**TOTAL General Services**	0	2,351	0	0	0	0	0	0	0	0	0	2,351	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	15,000	0	0	0	0	0	0	0	0	0	15,000	17
18	Directors Fees	0	2,250	0	0	0	0	0	0	0	0	0	2,250	18
19	Professional Services	0	1,558	0	0	0	0	0	0	0	0	0	1,558	19
20	Fees, Subscriptions & Promotions	(50)	577	0	0	0	0	0	0	0	0	0	527	20
21	Clerical & General Office Expenses	0	1,377	0	3,803	0	0	0	0	0	0	0	5,180	21
22	Employee Benefits & Payroll Taxes	0	0	0	12,236	0	0	0	0	0	0	0	12,236	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	1,688	0	0	0	0	0	0	0	1,688	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	6,700	0	0	0	0	0	0	0	6,700	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50)	20,762	0	24,427	0	0	0	0	0	0	0	45,139	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50)	23,113	0	24,427	0	0	0	0	0	0	0	47,490	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Estates # 0036277 **Report Period Beginning:** 10/01/11 **Ending:** 09/30/12

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	875	0	0	0	0	0	0	0	875	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	4,200	0	0	0	0	0	0	0	4,200	34
35	Rent-Equipment & Vehicles	0	0	0	2,400	0	0	0	0	0	0	0	2,400	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	7,475	0	0	0	0	0	0	0	7,475	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)**	(50)	23,113	0	31,902	0	0	0	0	0	0	0	54,965	45

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	2	food	$ 313	Marion County Horizon Center	0.00%	$ 626	$ 313	1
2	V	3	housekeeping supplies	4	Marion County Horizon Center	0.00%	8	4	2
3	V	5	utilities	1,540	Marion County Horizon Center	0.00%	3,080	1,540	3
4	V	6	maintenance supplies	252	Marion County Horizon Center	0.00%	504	252	4
5	V	6	maintenance repairs	230	Marion County Horizon Center	0.00%	460	230	5
6	V	7	garbage pickup	12	Marion County Horizon Center	0.00%	24	12	6
7	V	17	management fees	15,000	Marion County Horizon Center	0.00%	30,000	15,000	7
8	V	18	director fees	2,250	Marion County Horizon Center	0.00%	4,500	2,250	8
9	V	19	accounting	1,558	Marion County Horizon Center	0.00%	3,116	1,558	9
10	V	20	license fees	250	Marion County Horizon Center	0.00%	500	250	10
11	V	20	dues/subscriptions	289	Marion County Horizon Center	0.00%	578	289	11
12	V	20	employee background checks	38	Marion County Horizon Center	0.00%	76	38	12
13	V	21	telephone	1,377	Marion County Horizon Center	0.00%	2,754	1,377	13
14	Total			$ 23,113			$	$ * 23,113	14

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

VII. RELATED PARTIES (continued)

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)	
15	V	21	office supplies	$ 1,211	Marion County Horizon Center	0.00%	$ 2,422	$ 1,211	15
16	V	21	computer expense	2,592	Marion County Horizon Center	0.00%	5,184	2,592	16
17	V	22	w/c insurance	11,484	Marion County Horizon Center	0.00%	22,968	11,484	17
18	V	22	emp. Health insurance	752	Marion County Horizon Center	0.00%	1,504	752	18
19	V	25	gas/oil	928	Marion County Horizon Center	0.00%	1,856	928	19
20	V	25	trans rep/main	760	Marion County Horizon Center	0.00%	1,520	760	20
21	V	26	building insurance (facility)	6,700	Marion County Horizon Center	0.00%	13,400	6,700	21
22	V	30	depreciation	875	Marion County Horizon Center	0.00%	1,750	875	22
23	V	34	other rent	4,200	Marion County Horizon Center	0.00%	8,400	4,200	23
24	V	35	vehicle rent	2,400	Marion County Horizon Center	0.00%	4,800	2,400	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 31,902			$ 63,804	$ * 31,902	39

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	None		Richland Manor	Olney	(Marion County	Salem	Parent Company	1
2					Horizon Center)			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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Terry Elwood	Director	Board Member	0.00	1,150	2	6.00	Director Fee	$ 1,150	L18 C7	1
2	Amanda Miller	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18 C7	2
3	Julie Quinn	Director	Board Member	0.00	550	1	3.00	Director Fee	550	L18 C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,250		13

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

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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	2	Food	Facilities	2	2	$ 626	$ 0	1	$ 313	1
2	3	Housekeeping Supplies	Facilities	2	2	7	0	1	4	2
3	5	Utilities	Facilities	2	2	3,080	0	1	1,540	3
4	6	Maintenance Supplies	Facilities	2	2	504	0	1	252	4
5	6	Maintenance Repairs	Facilities	2	2	460	0	1	230	5
6	7	Garbage Pickup	Facilities	2	2	24	0	1	12	6
7	17	Management Fees	Facilities	2	2	30,000	0	1	15,000	7
8	18	Director Fees	Facilities	2	2	4,500	0	1	2,250	8
9	19	Accounting	Facilities	2	2	3,116	0	1	1,558	9
10	20	License Fees	Facilities	2	2	500	0	1	250	10
11	20	Dues & Subscriptions	Facilities	2	2	578	0	1	289	11
12	20	Employee Background Checks	Facilities	2	2	75	0	1	38	12
13	21	Telephone	Facilities	2	2	2,753	0	1	1,377	13
14	21	Office Supplies	Facilities	2	2	2,421	0	1	1,211	14
15	21	Computer Expense	Facilities	2	2	5,183	0	1	2,592	15
16	22	W/C Insurance	Facilities	2	2	22,968	0	1	11,484	16
17	22	Emp. Health Insurance	Facilities	2	2	1,504	0	1	752	17
18	22	State Unemp. Taxes	Facilities	2	2	0	0	1	0	18
19	25	Gas & Oil	Facilities	2	2	1,856	0	1	928	19
20	25	Trans. Rep & Main	Facilities	2	2	1,520	0	1	760	20
21	26	Building Insurance	Facilities	2	2	13,399	0	1	6,700	21
22	30	Depreciation	Facilities	2	2	1,750	0	1	875	22
23	34	Other Rent	Facilities	2	2	8,400	0	1	4,200	23
24	35	Vehicle Rent	Facilities	2	2	4,800	0	1	2,400	24
25	TOTALS					$ 110,024	$		$ 55,015	25

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

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

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

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

Facility Name & ID Number Prairie Estates # 0036277 **Report Period Beginning:** 10/01/11 **Ending:** 09/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **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:			
	2007	None	8
	2008	None	9
	2009	None	10
	2010	None	11
	2011	None	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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: 10/01/11 Ending: 09/30/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 332,061	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		20			11,838	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		3,331	21
22	Roof Replacement (Shingles)			2003	8,715	436	20	436		3,997	22
23	Replace Decking & substructure			2003	4,640	232	20	232		2,127	23
24	Bathroom Remodeling			2003	6,845	342	20	342		3,107	24
25	Bathroom Tub & shower replaced/remodeled			2004	8,598	430	20	430		3,619	25
26	Remodel Kitchen/cabinets			2005	4,906	327	15	327		2,425	26
27	Cabinets bathroom/laundry			2006	4,948	247	20	247		1,709	27
28	Plumbing kitchen area			2006	2,267	151	15	151		1,045	28
29	Bathroom Remodeling			2007	24,751	1,238	20	1,238		6,809	29
30	Heating duct repair/replacement			2007	7,649	510	15	510		2,677	30
31	Replace subfloor furnace room			2007	1,535	102	15	102		527	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: 10/01/11 Ending: 09/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	$ 19,934		$ 19,934	$	$ 405,851	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: 10/01/11 Ending: 09/30/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 53,762	$ 1,451	$ 1,451	$	10	$ 52,495	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Equipment	519	74	74		7	157	74
75	TOTALS	$ 54,281	$ 1,525	$ 1,525	$		$ 52,652	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Transportation	1999 Dodge Van	1999	$ 23,106	$	$	$	4	$ 23,106	76
77	Used Handicapped Van	1999 Ford Ecoline Sport Van	2010	8,500	2,125	2,125		4	4,817	77
78		(with wheelchair lift)								78
79	Errands (Shared 50%)	2004 GMC Envoy	2010	5,250	1,094	1,094		4	2,188	79
80	TOTALS			$ 36,856	$ 3,219	$ 3,219	$		$ 30,111	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)	$ 611,091	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,678	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,678	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)	$ 488,614	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: 10/01/11 Ending: 09/30/12

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	Home Office	1987		3/09/92	4,200			5
6								6
7	TOTAL				$ 4,200 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/09/2009
Ending 3/09/2014

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

	Fiscal Year Ending	Annual Rent
12.	09/30/2013	$ 4,200
13.	09/30/2014	$ month by month
14.	09/30/2015	$ month by month

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	2010 GMC Terrain	$ 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: 10/01/11 Ending: 09/30/12

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.

This training was mandatory 5-year re-training.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[ ]
HOURS PER CNA	8

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
HOURS PER CNA	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		21		21
3	Classroom Wages (a)		902		902
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		44		44
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 967	$	$ 967
10	SUM OF line 9, col. 1 and 2 (e)	$ 967			

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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(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 # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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	$ 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:** 10/01/11 **Ending:** 09/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/12 (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	$ 160,514	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,689		3
4	Supply Inventory (priced at cost)	2,038		4
5	Short-Term Investments	218,311		5
6	Prepaid Insurance	620		6
7	Other Prepaid Expenses	81		7
8	Accounts Receivable (owners or related parties)	50,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 734,253	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,000		13
14	Buildings, at Historical Cost	405,868		14
15	Leasehold Improvements, at Historical Cost	107,086		15
16	Equipment, at Historical Cost	76,322		16
17	Accumulated Depreciation (book methods)	(478,437)		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)**	$ 117,839	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 852,092	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,471	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,081		30
31	Accrued Taxes Payable (excluding real estate taxes)	532		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)**	$ 21,084	$	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)**	$ 21,084	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 831,008	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 852,092	$	48

***(See instructions.)**

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 813,217	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 813,217	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	17,791	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)**	$ 17,791	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)**	$ 831,008	24 *

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

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 586,131	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 586,131	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	1,594	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	1,000	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,594	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,135	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Sale	7	28
28a	Unrealized Gain in Stock	51,491	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,498	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 648,358	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	157,672	31
32	Health Care	220,913	32
33	General Administration	191,116	33
	B. Capital Expense		
34	Ownership	23,803	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 630,567	40
41	**Income before Income Taxes (line 30 minus line 40)****	17,791	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 17,791	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 586,131	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 586,131	49

* **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: 10/01/11 Ending: 09/30/12

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	1,514	1,570	15,322	9.76	9
10	Activity Assistants	585	585	5,594	9.56	10
11	Social Service Workers	200	200	3,000	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,425	1,569	16,686	10.63	14
15	Cook Helpers/Assistants	2,695	2,863	27,315	9.54	15
16	Dishwashers					16
17	Maintenance Workers	185	185	4,651	25.14	17
18	Housekeepers	2,817	2,953	29,861	10.11	18
19	Laundry					19
20	Administrator	1,200	1,248	33,174	26.58	20
21	Assistant Administrator	1,598	1,678	21,312	12.70	21
22	Other Administrative	200	200	3,000	15.00	22
23	Office Manager					23
24	Clerical	599	627	6,987	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	980	1,020	23,917	23.45	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	14,607	15,083	150,278	9.96	30
31	Medical Records					31
32	Other Health C: H.A. Trainer	4	4	44	11.00	32
33	Other(specify) H.A. Trainees	72	72	902	12.53	33
34	TOTAL (lines 1 - 33)	28,681	29,857	$ 342,043 *	$ 11.46	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	$ 1,385	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	269	5,913	L10 C3	38
39	Pharmacist Consultant	12	220	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	48	3,600	L10 C3	47
48	Psychologist Consultant	21	2,058	L10 C3	48
49	TOTAL (lines 35 - 48)	374	$ 13,176		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: 10/01/11 Ending: 09/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trena Briscoe, LNHA	Administrator	0%	$ 33,218
Lisa Agee	Asst. Admn.	0%	21,312
Char Watton, MSW	Administrative	0%	3,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,530

B. Administrative - Other

Description	Amount
	$
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 Management Corp	Admn. Consulting Fees	$ 91,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 91,200

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,678
Unemployment Compensation Insurance	0
FICA Taxes	26,160
Employee Health Insurance	752
Employee Meals	1,327
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Flu Shots	85
TOTAL (agree to Schedule V, line 22, col.8)	$ 40,002

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

Description	Line #	Amount
TOTAL		$ None

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 9)	353
Patient Background Checks 0	
Ad	50
License Fees	10
Dues/Subscriptions	326
License Fees	250
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 939

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	
See attached schedule	747
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 747

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Prairie Estates # 0036277 Report Period Beginning: 10/01/11 Ending: 09/30/12

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

Facility Name & ID Number Prairie Estates # 0036277 **Report Period Beginning:** 10/01/11 **Ending:** 09/30/12

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. $ **95** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **37,063**
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. $ **1,000**
c. What percent of all travel expense relates to transportation of nurses and patients? **77.88%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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

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

To reclassify free employee meals from food costs to employee benefits

2	Medically Necessary Transportation, Line 38	$1,000	
	Program Transportation, Line 14		$1,000

To reclassify medical transportation for clients per the separate DPA contract

3	Other Admn. Staff Transportation, Line 25	$144	
	Program Transportation, Line 14		$144

According to the facility's 16-Passenger van mileage log, 2,602 miles were driven this fiscal year (113,471 less 110,869.)
Of that, 6 miles were for unloaded errand miles for the facility.
According to the facility's wheelchair van mileage log, 4,085 miles were driven this fiscal year (97,858 less 93,773.)
Of that, 168 miles were for unloaded errand miles for the facility.
Therefore:
Line 25 Other Admn. Travel = (6 +168 miles)/(2,602 + 4,085 miles) x $5547 = $144

4	Travel and Seminar, Line 24	$194	
	Other Admn. Staff Transportation, Line 25		$194

To reclassify mileage paid for seminars/training.

Schedule V Line Reference	Item	Total Marion County Horizon Center Expenses	% of Ownership	Allocation Prairie Estates	Allocation Richland Manor
2	Food	$626	0%	$313	$313
3	Housekeeping Supplies	$8	0%	$4	$4
5	Utilities	$3,080	0%	$1,540	$1,540
6	Maintenance Supplies	$504	0%	$252	$252
6	Maintenance Repairs	$460	0%	$230	$230
7	Garbage Pick-up	$24	0%	$12	$12
17	Management Fees	$30,000	0%	$15,000	$15,000
18	Director Fees	$4,500	0%	$2,250	$2,250
19	Accounting	$3,116	0%	$1,558	$1,558
20	License fees	$500	0%	$250	$250
20	Dues & Subscriptions	$578	0%	$289	$289
20	Employee Background Checks	$76	0%	$38	$38
21	Telephone	$2,754	0%	$1,377	$1,377
21	Office Supplies	$2,422	0%	$1,211	$1,211
21	Computer Expense	$5,184	0%	$2,592	$2,592
22	W/C Insurance	$22,968	0%	$11,484	$11,484
22	Emp. Health Ins.	$1,504	0%	$752	$752
22	State Unemp Taxes	$0	0%	$0	$0
25	Gas & Oil	$1,856	0%	$928	$928
25	Trans. Rep & Main.	$1,520	0%	$760	$760
26	Building Insurance	$13,400	0%	$6,700	$6,700
30	Depreciation	$1,750	0%	$875	$875
34	Other Rent	$8,400	0%	$4,200	$4,200
35	Vehicle Rent	$4,800	0%	$2,400	$2,400
		$110,030		$55,015	$55,015

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

Non-profit Home: No direct services were provided by any of the Board members. No Board member has any relationship with any entity that conducted business with Marion County Horizon Center, Prairie Estates, or Richland Manor during the reporting period nor during any other time period.

Travel and Seminar, Line 24:

Job Title	Date	Location	Title	Sponsor	Seminar Cost	Mileage Paid	Hotel Cost	Food Costs	Total Costs
Bookkeeper	10/13/2011	Oak Lawn	CILA Seminar	DHS	$0	$0	$0	$7	$7
Administrator	11/8/2011	Carterville	Dementia		$0	$87	$0	$0	$87
Activity Director	4/17/2012	Charleston	Training	Special Olympics	$0	$65	$0	$0	$65
Manager	5/4/2012	Springfield	Training for Cila	DHS	$0	$42	$117	$0	$159
Bookkeeper	5/10/2012	Oak Lawn	CILA Seminar	DHS	$0	$0	$184	$57	$241
8 Staff	7/16/2012	Flora	OIG Training	OIG	$0	$0	$0	$123	$123
Asst. Admn	6/20/2012	Albion	Transportation	DHS	$0	$42	$0	$23	$65
					$0	$236	$301	$210	$747

Other Admn. Transportation, Line 25

Reimbursement to employees for administrative miles were reimbursed at a rate of $.45/mile for the period 10/01/11 to 09/30/12. Detailed logs of these miles are maintained at the facility.

Tt miles reimbursed - 2,268 miles x $.45/mile	$1,021
Less miles re-classed to Travel & Seminar	-$194
Rep/Main, gas&oil for vehicles (fm home office)	$1,688
174 miles logged onto vans for administrative u	$144
Line 25, Column 8	$2,659

Schedule XX, Line 12:

Trena Briscoe's pay has been allocated as follows:

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

Charlotte Watton's hours have been allocated as follows:

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

	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Component Life	Accm Dep.
Equipment (Purchased in Prior Years)						
Home Office	$1,038	$148			7	
% Home Office Allocated	x.5	x.5				
	$519	$74	$74			$157
Prairie Estates Equipment	$53,762	$1,451	$1,451	0		$52,495
Total XI-C, Line 75	$54,281	$1,525	$1,525	0		$52,652