

Facility Name & ID Number Prairie Rose Health Care Ctr

0045245 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,865	3,319	2,012	20,196	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,865	3,319	2,012	20,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.70%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 105 and days of care provided 1,249

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Prairie Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	137,116	12,719		149,835		149,835		149,835		1
2	Food Purchase		141,000		141,000		141,000	(5,736)	135,264		2
3	Housekeeping	126,810	21,190		148,000		148,000		148,000		3
4	Laundry	18,415	5,210		23,625		23,625		23,625		4
5	Heat and Other Utilities			109,036	109,036		109,036		109,036		5
6	Maintenance	34,857	10,739	25,987	71,583		71,583		71,583		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	317,198	190,858	135,023	643,079		643,079	(5,736)	637,343		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,062,367	141,275	4,646	1,208,288		1,208,288		1,208,288		10
10a	Therapy	154,006	73	147,993	302,072		302,072		302,072		10a
11	Activities	31,695		222	31,917		31,917	(2,400)	29,517		11
12	Social Services	37,415			37,415		37,415		37,415		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,285,483	141,348	173,861	1,600,692		1,600,692	(2,400)	1,598,292		16
	C. General Administration										
17	Administrative	48,842		279,758	328,600		328,600		328,600		17
18	Directors Fees										18
19	Professional Services			53,300	53,300		53,300	(35,373)	17,927		19
20	Dues, Fees, Subscriptions & Promotions			6,659	6,659		6,659		6,659		20
21	Clerical & General Office Expenses		16,442	19,168	35,610		35,610	(1,021)	34,589		21
22	Employee Benefits & Payroll Taxes			204,718	204,718		204,718		204,718		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			13,704	13,704		13,704	(11,621)	2,083		25
26	Insurance-Prop.Liab.Malpractice			54,584	54,584		54,584		54,584		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	48,842	16,442	631,891	697,175		697,175	(48,015)	649,160		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,651,523	348,648	940,775	2,940,946		2,940,946	(56,151)	2,884,795		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 Ctr

#0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			153,599	153,599		153,599	(18,746)	134,853			30
31	Amortization of Pre-Op. & Org.			12,568	12,568		12,568		12,568			31
32	Interest			187,022	187,022		187,022	(1,262)	185,760			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			61,254	61,254		61,254		61,254			35
36	Other (specify):*											36
37	TOTAL Ownership			414,443	414,443		414,443	(20,008)	394,435			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,661		54,661		54,661		54,661			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,245	180,245		180,245		180,245			42
43	Other (specify):*	33,948	472	111,565	145,985		145,985	(145,985)				43
44	TOTAL Special Cost Centers	33,948	55,133	291,810	380,891		380,891	(145,985)	234,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,685,471	403,781	1,647,028	3,736,280		3,736,280	(222,144)	3,514,136			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 Ctr

0045245

Report Period Beginning: 1/1/14

Ending: 12/31/14

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,736)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,326)	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	(18,746)	30		9
10	Interest and Other Investment Income	(1,262)	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	(36,456)	43		18
19	Entertainment				19
20	Contributions	(125)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,015)	43		24
25	Fund Raising, Advertising and Promotional	(1,559)	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	(101,919)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (222,144)		\$	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	2	
		Amount	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)		Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (222,144)		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	2	3	4	
		Yes	No	Amount	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 Ctr

ID# 0045245

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (12,666)	43	1
2	X-Rays-Part A	(3,194)	43	2
3	Pet Expense	(1,192)	43	3
4	Special Events	(32)	43	4
5	Miscellaneous Revenue Offset-Office Supplies	(1,021)	21	5
6	Disallowed R.E. Taxes	0	33	6
7	Offset Transportation Revenue	(2,400)	11	7
8	Legal Expense	(23,373)	19	8
9	Professional Fees	(12,000)	19	9
10	Non-Allowable Mileage	(11,621)	25	10
11	Marketing Salary and Supplies	(34,420)	43	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		(101,919)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Rose Health Care Ctr# 0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,736)	0	0	0	0	0	0	0	0	0	0	(5,736)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,736)	0	0	0	0	0	0	0	0	0	0	(5,736)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,373)	0	0	0	0	0	0	0	0	0	0	(35,373)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,021)	0	0	0	0	0	0	0	0	0	0	(1,021)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(11,621)	0	0	0	0	0	0	0	0	0	0	(11,621)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(48,015)	0	0	0	0	0	0	0	0	0	0	(48,015)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,151)	0	0	0	0	0	0	0	0	0	0	(56,151)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(18,746)	0	0	0	0	0	0	0	0	0	0	(18,746)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,262)	0	0	0	0	0	0	0	0	0	0	(1,262)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,008)	0	0	0	0	0	0	0	0	0	0	(20,008)	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):*	(145,985)	0	0	0	0	0	0	0	0	0	0	(145,985)	43
44	TOTAL Special Cost Centers	(145,985)	0	0	0	0	0	0	0	0	0	0	(145,985)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(222,144)	0	0	0	0	0	0	0	0	0	0	(222,144)	45

Facility Name & ID Number

Prairie Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SJL Health Systems, Inc.	100	South Shore Health Care, LLC	Gary, Indiana	None		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 1/1/2014

Period End 12/31/2014

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 Ctr # 0045245 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

0045245

Report Period Beginning:

1/1/14

Ending: 12/31/14

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____
 Fax Number (_____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8		N/A							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 Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Wells Fargo		X	Mortgage	\$21,167.65	12/01/02	\$ 3,580,869	\$ 2,989,614	11/01/35	0.0618	\$ 187,022	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$21,167.65		\$ 3,580,869	\$ 2,989,614			\$ 187,022	9						
B. Non-Facility Related*																		
10												10						
11									Interest Income Offset		(1,262)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(1,262)	14						
15	TOTALS (line 9+line14)						\$ 3,580,869	\$ 2,989,614			\$ 185,760	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		2013		\$	31	2
3. Under or (over) accrual (line 2 minus line 1).				\$	31	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			Disallowed R.E. Taxes			(31)
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$		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:		2009	_____	55	8	
		2010	_____	49	9	
		2011	_____	24	10	
		2012	_____	27	11	
		2013	_____	31	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 2013	\$		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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Ctr

0045245 Report Period Beginning:

1/1/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 443,042 2. Number of Years Over Which it is Being Amortized: 35
 3. Current Period Amortization: 12,568 4. Dates Incurred: January to December

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	<u>Facility</u>	<u>28,000</u>	<u>1995</u>	<u>\$ 13,500</u>	1
2					2
3	TOTALS	28,000		\$ 13,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121	1995	1976	\$ 1,068,665	\$	30	\$ 35,622	\$ 35,622	\$ 706,504	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	1986 Additions		1986	970,363		30	32,345	32,345	908,363	9
10	1987 Additions		1987	110,922		29	3,825	3,825	103,009	10
11	1989 Additions		1989	2,219		10			2,219	11
12	1990 Additions		1990	4,295		30			4,295	12
13	1991 Additions		1991	134,283		7			134,283	13
14	1992 Additions		1992	17,130		7			17,130	14
15	1993 Additions		1993	24,239		7			24,239	15
16	1994 Additions		1994	10,559		7			10,559	16
17	1995 Additions		1995	14,617		15			14,617	17
18	1996 Additions		1996	305,057		12			305,057	18
19	1997 Additions		1997	23,542		10			23,542	19
20	Whirlpool Bath		1998	9,120		10			9,120	20
21	Lift, Bath Trolley		1998	3,850		10			3,850	21
22	Shower Room		1998	4,884		10			4,884	22
23	Entrance Doors		1998	2,358		20	118	118	1,917	23
24	Curtains		1998	6,102		5			6,102	24
25	Sidewalk & Pad		1999	1,484		15	41	99	1,484	25
26	Divide Receipts on Emergency Generator		1999	2,397		20	120	120	1,859	26
27	Med Room Cabinets and Counter Top		1999	2,008		20	100	100	1,504	27
28	Heat/Cool		2000	1,876		7			1,876	28
29	Door Alarms		2001	1,215		15	81	81	1,026	29
30	Dining Room, Living Room, Shower Remodel		2001	94,315		30	3,144	3,144	42,705	30
31	Wooded Doors		2001	1,900		15	127	127	1,660	31
32	Landscaping-Renovation Project		2001	1,174		10			1,174	32
33	Bituminous Parking Lot		2001	22,030		8			22,030	33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replace Plumbing Fixtures	2002	\$ 2,490	\$	20	\$ 125	\$ 125	\$ 1,622	37
38	Therapy Room Remodel	2002	5,617		20	281	281	3,512	38
39	Remodel Medication/Utility Rooms	2002	7,909		20	395	395	4,940	39
40	2 Heating/Cooling Roof Top Units	2002	11,300		10			11,300	40
41	Breakroom Remodel	2002	3,106		10			3,106	41
42	Exterior Window Covering	2002	7,650		7			7,650	42
43	Lights for Therapy Room	2002	805		10			805	43
44	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	22,258	44
45	Fire Suppression System	2004	1,540		10	141	154	1,540	45
46	Antenna	2004	2,944		10	52	294	2,944	46
47	Sign	2004	1,200		10	120	120	1,200	47
48	Carpet	2005	1,281		5			1,281	48
49	Sidewalks	2006	8,735		10	874	874	7,459	49
50	Duct Work	2007	5,120		15	342	342	2,565	50
51	Water Heater	2007	5,378		10	538	538	4,035	51
52	Sidewalks	2007	8,976		15	598	598	4,485	52
53	Water Heater & Duct Work	2008	4,850		10	485	485	3,153	53
54	Air Conditioner-Rooftop	2008	9,120		10	912	912	5,928	54
55	Plumbing Repair	2008	3,442		10	344	344	2,408	55
56	Ceramic Tile Replacement	2008	9,996		20	500	500	3,250	56
57	Vinyl Tile Replacement	2008	4,495		20	225	225	1,575	57
58	Sidwalk Marquee	2008	4,985		10	499	499	3,243	58
59	Generator Repair	2008	2,562		10	256	256	1,664	59
60	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	4,706	60
61	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	4,277	61
62	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	8,242	62
63	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	3,510	63
64	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	6,773	64
65	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	9,711	65
66	Tiling for Bathroom	2009	13,519		15	902	902	4,961	66
67	Generator Repair	2009	3,984		7	570	570	3,135	67
68	Air Conditioner-Rooftop	2009	10,281		15	686	686	3,773	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,133,234	\$		\$ 91,936	\$ 92,249	\$ 2,506,019	70

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

Facility Name & ID Number Prairie Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,133,234	\$		\$ 91,936	\$ 92,249	\$ 2,506,019	1
2	Wandering Patient Alarm System	2010	5,050		7	722	722	3,249	2
3	Sprinkler System Repair	2010	33,658		10	3,366	3,366	15,147	3
4	Water Heater	2011	3,356		7	480	480	1,680	4
5	Fire Alarm Control Installation	2012	2,958		7	422	422	1,055	5
6	Landscaping	2013	10,158		15	678	339	1,017	6
7	Parking Lot Repair	2013	2,500		7	358	179	537	7
8	Water Pipe Repair	2014	7,170		7	683	683	683	8
9	Gutters and Soft	2014	7,936		25	185	185	185	9
10	Patio Replacement	2014	9,592		15	320	320	320	10
11	Roof Replacement	2014	34,544		25	691	691	691	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	Land Improvements Booked			2,506			(2,506)		27
28	Building Booked			100,224			(100,224)		28
29	Building Improvements Booked			15,091			(15,091)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,250,156	\$ 117,821		\$ 99,841	\$ (18,185)	\$ 2,530,583	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 349,825	\$ 35,749	\$ 34,983	\$ (766)	5-10 yrs.	\$ 234,798	71
72	Current Year Purchases	2,400	29	29		7	29	72
73	Fully Depreciated Assets	748,338					748,338	73
74	Home Office Allocation							74
75	TOTALS	\$ 1,100,563	\$ 35,778	\$ 35,012	\$ (766)		\$ 983,165	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,364,219	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 153,599	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 134,853	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,746)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,513,748	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Prairie Rose Health Care Ctr

0045245

Report Period Beginning: 1/1/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 46,906

Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Prairie Rose Health Care Ctr

0045245

Period Beginning 1/1/2014

Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 41,162
Dishwasher	717
Laundry Equipment	
Copier	5,027
	<hr/>
	46,906
	<hr/> <hr/>

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/14 Ending: 12/31/14
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,548	\$ 53,217	\$	3,548	\$ 53,217	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,172	17,576		1,172	17,576	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		5,147	77,200	73	5,147	77,273	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 prescripts				54,661		54,661	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(1)	7519 hours		154,006			7,519	154,006	13	
14	TOTAL			\$	154,006	9,867	\$ 147,993	\$ 54,734	17,386	\$ 356,733	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.

Facility Name & ID Number Prairie Rose Health Care Ctr

0045245

Report Period Beginning: 1/1/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	\$ 82,139	\$ 82,139	1
2	Cash-Patient Deposits	47,953	47,953	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>258,566</u>)	496,540	496,540	3
4	Supply Inventory (priced at <u>Cost</u>)	13,727	13,727	4
5	Short-Term Investments			5
6	Prepaid Insurance	44,021	44,021	6
7	Other Prepaid Expenses	10,267	10,267	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 694,647	\$ 694,647	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	67,073	13,500	13
14	Buildings, at Historical Cost	2,842,209	1,068,665	14
15	Leasehold Improvements, at Historical Cost	287,282	2,181,491	15
16	Equipment, at Historical Cost	1,195,560	1,100,563	16
17	Accumulated Depreciation (book methods)	(3,368,695)	(3,513,748)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan Costs</u>)	265,149	265,149	22
23	Other(specify): <u>Escrows and Reserves</u>	469,449	469,449	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,758,027	\$ 1,585,069	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,452,674	\$ 2,279,716	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,274,362	\$ 1,274,362	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,953	47,953	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,182	122,182	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,188	31,188	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	54,494	54,494	35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	4,873	4,873	36
37	<u>Accrued Management Fees</u>	593,457	593,457	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,128,509	\$ 2,128,509	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,989,614	2,989,614	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	351,000	351,000	43
44	<u>Due to Tutores</u>	318,743	318,743	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,659,357	\$ 3,659,357	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,787,866	\$ 5,787,866	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,335,192)	\$ (3,508,150)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,452,674	\$ 2,279,716	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,038,397)	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,038,401)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(286,791)	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	(10,000)	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)	\$ (296,791)	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)	\$ (3,335,192)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,270,680	1
2	Discounts and Allowances for all Levels	(235,671)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,035,009	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	273,837	6
7	Oxygen	1,292	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 275,129	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	5,736	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,896	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,197	20
21	Other Medical Services	31,839	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 134,668	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,262	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,262	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,021	28
28a	Transportation Revenue	2,400	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,421	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,449,489	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	643,079	31
32	Health Care	1,600,692	32
33	General Administration	697,175	33
B. Capital Expense			
34	Ownership	414,443	34
C. Ancillary Expense			
35	Special Cost Centers	200,646	35
36	Provider Participation Fee	180,245	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,736,280	40
41	Income before Income Taxes (line 30 minus line 40)**	(286,791)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (286,791)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,093,612	44
45	Private Pay - Net Inpatient Revenue	474,913	45
46	Medicare - Net Inpatient Revenue	518,500	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	183,655	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(235,671)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,035,009	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 Rose Health Care Ctr

0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,009	2,081	\$ 59,435	\$ 28.56	1
2	Assistant Director of Nursing	788	916	24,536	26.79	2
3	Registered Nurses	3,356	3,513	90,820	25.85	3
4	Licensed Practical Nurses	13,025	13,711	267,684	19.52	4
5	CNAs & Orderlies	51,024	52,989	565,911	10.68	5
6	CNA Trainees					6
7	Licensed Therapist	7,234	7,519	154,006	20.48	7
8	Rehab/Therapy Aides	781	781	14,090	18.04	8
9	Activity Director	1,878	2,069	22,167	10.71	9
10	Activity Assistants	793	793	6,627	8.36	10
11	Social Service Workers	1,874	2,090	37,415	17.90	11
12	Dietician					12
13	Food Service Supervisor	1,867	2,018	22,316	11.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,744	12,240	114,800	9.38	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,106	34,857	16.55	17
18	Housekeepers	11,705	12,122	126,810	10.46	18
19	Laundry	1,852	1,980	18,415	9.30	19
20	Administrator	2,080	2,080	48,842	23.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	4,453	4,837	76,740	15.87	33
34	TOTAL (lines 1 - 33)	118,402	123,845	\$ 1,685,471 *	\$ 13.61	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 21,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,294	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 25,294		49

C. CONTRACT NURSES

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

Prairie Rose Health Care Ctr
 0045245
 Period Beginning
 Period End

1/1/2014
 12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,844	2,084	39,891	19.14
Transportation	250	250	2,901	11.60
Marketing	2,359	2,503	33,948	13.56
TOTAL	4,453	4,837	76,740	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Laura Morrell	Administrator	0	\$ 48,842	Workers' Compensation Insurance	\$ 55,289	IDPH License Fee	\$				
				Unemployment Compensation Insurance		Advertising: Employee Recruitment					
				FICA Taxes	123,357	Health Care Worker Background Check					
				Employee Health Insurance	(18,575)	(Indicate # of checks performed)					
				Employee Meals		Patient Background Checks	71 715				
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	619				
				Employee Relations	6,889	Miscellaneous Dues & Subscriptions	5,325				
				Employee Retirement	1,002						
				State Unemployment	36,756						
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 48,842	TOTAL (agree to Schedule V, line 22, col.8)			\$ 204,718	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,659	
(List each licensed administrator separately.)								Less: Public Relations Expense		()	
								Non-allowable advertising		()	
								Yellow page advertising		()	
B. Administrative - Other											
Description			Amount								
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 279,758								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 279,758								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount				
Ginoli & Company	Accounting Services	\$ 12,585				Out-of-State Travel	\$				
HK Payroll	Accounting Services	97									
Consolidated Communications	Computer Services	611									
Allscripts	Computer Services	1,949	N/A			In-State Travel					
Christian Co. Circuit Clerk	Filing Fees	150									
Shelby Co. Sheriff	Filing Fees	78									
E-Health Data Services	Computer Services	2,457				Seminar Expense					
Andy Paulson	Consulting Fees-NA	12,000									
Brown & James	Legal Fees-Non Allowable	23,373									
TOTAL (agree to Schedule V, line 19, column 3)			\$ 53,300	TOTAL			\$	Entertainment Expense ()			
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)			
								TOTAL			

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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 Ctr# 0045245

Report Period Beginning:

1/1/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,102 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. \$ 180,245
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,736
- (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. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adquate 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.