FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0045245

Facility Name: Prairie Rose Health Care Ctr

Address: 900 S Chestnut St (Number) Pana (City) 62557 (Zip Code)

County: Christian

Telephone Number: (217) 562-3996 **Fax #** (217) 562-4005

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2000

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

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

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	105	38,325	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,505	2,750	981	17,236	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,505	2,750	981	17,236	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.97%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 842

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	140,129	15,721	501	156,351		156,351		156,351			1
2	Food Purchase		119,770		119,770		119,770	(25,945)	93,825			2
3	Housekeeping	131,131	14,782		145,913		145,913		145,913			3
4	Laundry	18,714	17,470		36,184		36,184		36,184			4
5	Heat and Other Utilities			111,810	111,810		111,810		111,810			5
6	Maintenance	36,684	9,989	22,564	69,237		69,237		69,237			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	326,658	177,732	134,875	639,265		639,265	(25,945)	613,320			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	948,453	108,555	3,205	1,060,213		1,060,213		1,060,213			10
10a	Therapy	64,679		114,789	179,468		179,468		179,468			10a
11	Activities	31,006	189	379	31,574		31,574		31,574			11
12	Social Services	38,499			38,499		38,499		38,499			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,082,637	108,744	139,373	1,330,754		1,330,754		1,330,754			16
	C. General Administration											
17	Administrative	70,400		180,300	250,700		250,700		250,700			17
18	Directors Fees											18
19	Professional Services			17,817	17,817		17,817		17,817			19
20	Dues, Fees, Subscriptions & Promotions			3,580	3,580		3,580	(125)	3,455			20
21	Clerical & General Office Expenses		2,659	15,110	17,769		17,769	(99)	17,670			21
22	Employee Benefits & Payroll Taxes			157,987	157,987		157,987		157,987			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,036	1,036		1,036		1,036			25
26	Insurance-Prop.Liab.Malpractice			46,664	46,664		46,664		46,664			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	70,400	2,659	422,494	495,553		495,553	(224)	495,329			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,479,695	289,135	696,742	2,465,572		2,465,572	(26,169)	2,439,403			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: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			150,994	150,994		150,994	(10,987)	140,007			30
31	Amortization of Pre-Op. & Org.			12,568	12,568		12,568		12,568			31
32	Interest			178,232	178,232		178,232	(112)	178,120			32
33	Real Estate Taxes			37	37		37	(37)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,991	52,991		52,991		52,991			35
36	Other (specify):*											36
37	**TOTAL Ownership**			394,822	394,822		394,822	(11,136)	383,686			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,706		50,706		50,706		50,706			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,168	156,168		156,168		156,168			42
43	Other (specify):*	29,020	570	86,629	116,219		116,219	(116,219)				43
44	**TOTAL Special Cost Centers**	29,020	51,276	242,797	323,093		323,093	(116,219)	206,874			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,508,715	340,411	1,334,361	3,183,487		3,183,487	(153,524)	3,029,963			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: 1/1/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,672)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,701)	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	(10,987)	30		9
10	Interest and Other Investment Income	(112)	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	(63,759)	43		18
19	Entertainment				19
20	Contributions	(2,600)	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				24
25	Fund Raising, Advertising and Promotional	(2,783)	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	(64,910)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (153,524)		$	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)		Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (153,524)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Prairie Rose Health Care Ctr

ID# 0045245

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (12,868)	43	1
2	X-Rays-Part A	(2,153)	43	2
3	Pet Expense	(888)	43	3
4	Disallowed R.E. Taxes	(37)	33	4
5	Miscellaneous Revenue Offset-Food Supplies	(19,273)	2	5
6	Miscellaneous Revenue Offset-Nursing Supplies	(99)	21	6
7	Disallowed Marketing Expense	(29,020)	43	7
8	Disallowed Special Events	(447)	43	8
9	Disallowed Chamber of Commerce Dues	(125)	20	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**	(64,910)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,945)	0	0	0	0	0	0	0	0	0	0	(25,945)	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**	(25,945)	0	0	0	0	0	0	0	0	0	0	(25,945)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(125)	0	0	0	0	0	0	0	0	0	0	(125)	20
21	Clerical & General Office Expenses	(99)	0	0	0	0	0	0	0	0	0	0	(99)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(224)	0	0	0	0	0	0	0	0	0	0	(224)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,169)	0	0	0	0	0	0	0	0	0	0	(26,169)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,987)	0	0	0	0	0	0	0	0	0	0	(10,987)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112)	0	0	0	0	0	0	0	0	0	0	(112)	32
33	Real Estate Taxes	(37)	0	0	0	0	0	0	0	0	0	0	(37)	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**	(11,136)	0	0	0	0	0	0	0	0	0	0	(11,136)	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):*	(116,219)	0	0	0	0	0	0	0	0	0	0	(116,219)	43
44	**TOTAL Special Cost Centers**	(116,219)	0	0	0	0	0	0	0	0	0	0	(116,219)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(153,524)	0	0	0	0	0	0	0	0	0	0	(153,524)	45

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1									$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9		N/A								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: 1/1/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Wells Fargo		X	Mortgage	$21,167.65	12/01/02	$ 3,580,869	$ 2,868,366	11/01/35	0.0618	$ 178,232	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	$ 2,868,366			$ 178,232	9
	B. Non-Facility Related*											
10								Interest Income Offset			(112)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (112)	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 2,868,366			$ 178,120	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A

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

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	37	2
3. Under or (over) accrual (line 2 minus line 1).	$	37	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Disallowed R.E. Taxes**		(37)	
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.	$	0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	24	8
	2012	27	9
	2013	31	10
	2014	34	11
	2015	37	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 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Ctr COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-25-21-401-010-00	Land	$ 37.10	$ 37.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37.10	$ 37.10

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] 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: 2013

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	28,000	1995	$ 13,500	1
2					2
3	TOTALS	28,000		$ 13,500	3

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	121		1995	1976	$ 1,068,665	$	30	$ 35,622	$ 35,622	$ 777,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363		30	29,655	29,655	970,363	9
10	1987 Additions			1987	110,922		30	3,825	3,825	110,659	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	14,167		15			14,167	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	2,153	23
24	Curtains			1998	6,102		5			6,102	24
25	Sidewalk & Pad			1999	1,484		15			1,484	25
26	Divide Receipts on Emergency Generator			1999	2,397		20	120	120	2,099	26
27	Med Room Cabinets and Counter Top			1999	2,008		20	100	100	1,704	27
28	Door Alarms			2001	1,215		15	81	81	1,188	28
29	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	48,993	29
30	Wooded Doors			2001	1,900		15	113	113	1,900	30
31	Landscaping-Renovation Project			2001	1,174		10			1,174	31
32	Bituminous Parking Lot			2001	22,030		8			22,030	32
33	Replace Plumbing Fixtures			2002	$ 2,490	$	20	$ 125	125	1,872	33
34	Therapy Room Remodel			2002	5,617		20	281	281	4,074	34
35	Remodel Medication/Utility Rooms			2002	7,909		20	395	395	5,730	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: 1/1/2016 Ending: 12/31/2016

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	Breakroom Remodel	2002	3,106		10		$	$ 3,106	37
38	Exterior Window Covering	2002	7,650		7			7,650	38
39	Lights for Therapy Room	2002	805		10			805	39
40	Renovation on Facility Floors and Walls	2002	36,842		20	1,842	1,842	25,942	40
41	Fire Supression System	2004	1,540		10			1,540	41
42	Antenna	2004	2,944		10			2,944	42
43	Sign	2004	1,200		10			1,200	43
44	Carpet	2005	1,281		5			1,281	44
45	Sidewalks	2006	8,735		10	402	402	8,735	45
46	Duct Work	2007	5,120		15	342	342	3,249	46
47	Sidewalks	2007	8,976		15	598	598	5,681	47
48	Water Heater & Duct Work	2008	4,850		10	485	485	4,123	48
49	Air Conditioner-Rooftop	2008	9,120		10	912	912	4,662	49
50	Plumbing Repair	2008	3,442		10	344	344	3,096	50
51	Ceramic Tile Replacement	2008	9,996		20	500	500	4,250	51
52	Vinyl Tile Replacement	2008	4,495		20	225	225	2,025	52
53	Sidwalk Marquee	2008	4,985		10	499	499	4,241	53
54	Generator Repair	2008	2,562		10	256	256	2,176	54
55	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	6,154	55
56	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	5,593	56
57	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	10,778	57
58	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	4,590	58
59	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	8,857	59
60	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	12,699	60
61	Tiling for Bathroom	2009	13,519		15	902	902	6,765	61
62	Generator Repair	2009	3,984		7	279	279	3,984	62
63	Air Conditioner-Rooftop	2009	10,281		15	686	686	5,145	63
64	Wandering Patient Alarm System	2010	5,050		7	722	722	4,693	64
65	Sprinkler System Repair	2009	33,658		10	3,366	3,366	21,879	65
66	Water Heater	2011	3,356		7	480	480	2,640	66
67	Fire Alarm Control Installation	2012	2,958		7	422	422	1,899	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,159,252	$		$ 92,567	$ 92,567	$ 2,695,000	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: 1/1/2016 Ending: 12/31/2016

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		$ 3,159,252	$		$ 92,567	$ 92,567	$ 2,695,000	1
2	Landscaping	2013	10,158		15	678	678	2,373	2
3	Parking Lot Repair	2013	2,500		7	358	358	1,253	3
4	Water Pipe Repair	2014	7,170		7	1,024	1,024	2,560	4
5	Gutters and Soft	2014	7,936		25	317	317	793	5
6	Patio Replacement	2014	9,592		15	640	640	1,600	6
7	Roof Replacement	2015	222,650		25	8,906	8,906	13,359	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	Land Improvements Booked			2,069			(2,069)		27
28	Building Booked			98,162			(98,162)		28
29	Building Improvement Booked			26,772			(26,772)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,419,258	$ 127,003		$ 104,490	$ (22,513)	$ 2,716,938	34

**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: 1/1/2016 Ending: 12/31/2016

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	$ 358,695	$ 23,781	$ 35,360	$ 11,579	5-10 yrs.	$ 305,825	71
72	Current Year Purchases	2,200	210	157	(53)	7 yrs.	157	72
73	Fully Depreciated Assets	843,335					843,335	73
74	Home Office Allocation							74
75	TOTALS	$ 1,204,230	$ 23,991	$ 35,517	$ 11,526		$ 1,149,317	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										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)	$ 4,636,988	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,007	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,987)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,866,255	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			93
94	N/A		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: 1/1/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 38,643 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 32,847
Dishwasher	660
Copier	5,136
	38,643

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	3,069	$ 46,040	$	3,069	$ 46,040	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,196	17,935		1,196	17,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		3,388	50,814		3,388	50,814	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10(A)1, 10(A)3	3126	64,679			50,706	3,126		13
14	TOTAL			$ 64,679	7,653	$ 114,789	$ 50,706	10,779	$ 114,789	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:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ (13,522)	$ (13,522)	1
2	Cash-Patient Deposits	47,211	47,211	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,256)	1,080,568	1,080,568	3
4	Supply Inventory (priced at Cost)	13,727	13,727	4
5	Short-Term Investments			5
6	Prepaid Insurance	35,445	35,445	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Expenses	495	495	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,163,924	$ 1,163,924	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	509,932	2,350,593	15
16	Equipment, at Historical Cost	1,204,230	1,204,230	16
17	Accumulated Depreciation (book methods)	(3,672,486)	(3,866,255)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	443,042	443,042	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(203,029)	(203,029)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrows and Reserves	339,750	339,750	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,530,721	$ 1,350,496	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,694,645	$ 2,514,420	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 743,595	$ 743,595	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,211	47,211	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,239	110,239	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,014	8,014	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	58,890	58,890	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	17,158	17,158	35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	5,233	5,233	36
37	Accrued Management Fees	1,632,137	1,632,137	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,622,477	$ 2,622,477	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,868,366	2,868,366	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	351,000	351,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,219,366	$ 3,219,366	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,841,843	$ 5,841,843	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,147,198)	$ (3,327,423)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,694,645	$ 2,514,420	48

***(See instructions.)**

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,690,144)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,690,147)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(457,051)	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)**	$ (457,051)	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)**	$ (3,147,198)	24 *

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

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 2,562,824	1
2	Discounts and Allowances for all Levels	(196,871)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,365,953	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	214,224	6
7	Oxygen	896	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 215,120	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	6,672	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	88,669	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,750	20
21	Other Medical Services	19,693	21
22	Laundry	4,095	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 125,879	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Revenue	19,372	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,372	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,726,436	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	639,265	31
32	Health Care	1,330,754	32
33	General Administration	495,553	33
	B. Capital Expense		
34	Ownership	394,822	34
	C. Ancillary Expense		
35	Special Cost Centers	166,925	35
36	Provider Participation Fee	156,168	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,183,487	40
41	**Income before Income Taxes (line 30 minus line 40)****	(457,051)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (457,051)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,756,227	44
45	Private Pay - Net Inpatient Revenue	496,021	45
46	Medicare - Net Inpatient Revenue	98,790	46
47	Other-(specify) Insurance Net Revenue	14,915	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,365,953	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: 1/1/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,100	2,196	$ 58,268	$ 26.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,167	3,489	87,609	25.11	3
4	Licensed Practical Nurses	13,372	13,965	286,287	20.50	4
5	CNAs & Orderlies	39,932	41,366	468,707	11.33	5
6	CNA Trainees					6
7	Licensed Therapist	2,634	3,126	64,679	20.69	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,925	2,001	23,295	11.64	9
10	Activity Assistants	681	681	6,334	9.30	10
11	Social Service Workers	1,776	2,040	38,499	18.87	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,084	29,881	14.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,152	11,788	110,248	9.35	15
16	Dishwashers					16
17	Maintenance Workers	2,004	2,100	36,684	17.47	17
18	Housekeepers	11,978	12,289	131,131	10.67	18
19	Laundry	1,795	1,920	18,714	9.75	19
20	Administrator	2,080	2,080	70,400	33.85	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) See PG20A	3,660	3,798	77,979	20.53	33
34	TOTAL (lines 1 - 33)	100,200	104,923	$ 1,508,715 *	$ 14.38	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	8	$ 501		35
36	Medical Director	Monthly	21,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,711	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)	8	$ 25,211		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)		$		53

Prairie Rose Health Care Ctr
0045245
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,639	1,639	47,582	29.03
Transportation		140	140	1,377	9.84
Marketing		1,881	2,019	29,020	14.37
	TOTAL	3,660	3,798	77,979	

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Moore	Administrator	0	$ 70,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,400

B. Administrative - Other

Description	Amount
Management Fees	$ 180,300
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,300

C. Professional Services

Vendor/Payee	Type	Amount
Ginoli & Company	Accounting Services	$ 12,970
Consolidated Communications	Computer Services	597
Allscripts	Computer Services	961
E-Health Data Services	Computer Services	3,279
Sec. of State	Legal Fees	10
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 17,817

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,788
Unemployment Compensation Insurance	
FICA Taxes	107,140
Employee Health Insurance	4,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	6,533
Employee Retirement	2,225
TOTAL (agree to Schedule V, line 22, col.8)	$ 157,987

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	204
Health Care Worker Background Check	
(Indicate # of checks performed 27)	423
Patient Background Checks 34	538
Miscellaneous Licenses & Permits	1,420
Miscellaneous Dues & Subscriptions	995
Less: Public Relations Expense	(125)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,455

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Prairie Rose Health Care Ctr # 0045245 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $1000**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,014** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **156,168**
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. $ **6,672**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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. $ **N/A**

(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. **No**
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT **Prairie Rose Health Car** **11:39 AM** **7/7/2017**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-153,524	equal to	-153,524	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	178,120	equal to	178,120	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	12,568	equal to	12,568	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	140,007	equal to	140,007	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	52,991	equal to	52,991	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	179,468	equal to	179,468	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	50,706	equal to	50,706	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	639,265	equal to	639,265	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,330,754	equal to	1,330,754	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	495,553	equal to	495,553	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	394,822	equal to	394,822	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	166,925	equal to	166,925	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	156,168	equal to	156,168	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	948,453	equal to	948,453	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	64,679	equal to	0	64,679	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	31,006	equal to	31,006	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	38,499	equal to	38,499	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	140,129	equal to	140,129	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,684	equal to	36,684	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	131,131	equal to	131,131	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	18,714	equal to	18,714	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	70,400	equal to	70,400	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		#VALUE!	#VALUE!	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,508,715	equal to	1,508,715	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	501	< or = to	501	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	21,000	< or = to	21,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,711	< or = to	3,205	506	FAILED	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	379	-379	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	70,400	equal to	70,400	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	180,300	equal to	180,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	17,817	equal to	17,817	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	157,987	equal to	157,987	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,455	equal to	3,455	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav		equal to	0	#VALUE!	#VALUE!	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	156,168	equal to	156,168	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	842	equal to	981	-139	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to		0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,868,366	equal to	2,868,366	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	0	equal to		#VALUE!	#VALUE!	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	13,500	equal to	13,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,419,258	equal to	3,419,258	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,204,230	equal to	1,204,230	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,866,255	equal to	3,866,255	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-3,147,198	equal to	-3,147,198	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-457,051	equal to	-457,051	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,694,645	equal to	2,694,645	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!!** 7/7/2017 11:39:41 AM

HSA Number: 4 Name: **Prairie Rose Health Care Ctr**

Cost report peri From: 1/1/2016 To: 12/31/2016 Base Number: 492

If this is an ICF/DD 16 facility, e N

Licensed bed d 38,325 Occupancy: 17,236 Pct. of occupan 44.97%

ublic Aid Support Rate: $ ________

Genl Services S	326,658	Col 1, Line 8 ---Audit Adj:	________
Genl Admin Sal	70,400	Col 1, Line 28 ---Audit Adj:	________
Total Salary Wa	1,508,715	Col 1, Line 44 ---Audit Adj:	________
Employee Bene	157,987	Col 8, Line 22 ---Audit Adj:	________
Total General S	613,320	Col 8, Line 8 ---Audit Adj:	________
Total General A	495,329	Col 8, Line 28 ---Audit Adj:	________

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$326,658
Divided by Total Wages (Column 1, Line 44)	$1,508,715
General service wages as percent of total wages	21.6514%
Employee Benefits (Column 10, Line 22)	$157,987
Allocation of Employee Benefits to General Services Costs	$34,206
Plus Total General Services (Column 10, Line 8)	$613,320
New Total General Services Cost	$647,526

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$70,400
Divided by Total Wages (Column 1, Line 45)	$1,508,715
General administration wages as a percent of total wages	4.6662%
Employee Benefits (Column 10, Line 22)	$157,987
Allocation of Employee Benefits to General Admin. Costs	$7,372
Plus Total General Administration (Column 10, Line 28)	$495,329
Minus Total Fringe (Column 10, Line 22)	$157,987
New Total General Administration Cost	$344,714

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year ·	232	multiplied by 6 =	1392
Sum of the three lines			1399.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			492

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:	1
General Administration Multiplier:	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)	$647,526	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$647,526

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$344,714	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$344,714
3 Total Updated Support Costs (1 + 2)		$992,240

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $42.46

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$992,240
Total Patient Days (Cost Report)	17,236
Support Costs per Diem	$57.57

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	38,325
Multiplied by	0.93
	35,642
Minus total Patient Days	17,236
	18,406
One-third of difference	6,135
Plus Total Patient Days	17,236
Adjusted Occupancy	23,371
Total Support Costs (Step II, C, 3, above)	$992,240
Divided by Adjusted Occupany	23371
Support Costs Per Diem	$42.46

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$42.46
Difference	$4.98
Multiply the Difference by	0.5
One-Half of the Difference	$2.49
Plus Support Costs Per Diem	$42.46
Support Rate if costs are between 35th and 75th percentile	44.95

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$42.46
Difference	$4.98
Multiply the Difference by	0.5
One-Half of the Difference	$2.49
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$2.490
Plus Support Costs Per Diem	$42.46
Support Rate if support costs less than 35th percentile	$44.95

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$44.95**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	140,129	15,721	501	156,351	0	156,351	0	156,351
2. Food Purchase	-	119,770	-	119,770	0	119,770	-25,945	93,825
3. Housekeeping	131,131	14,782	-	145,913	0	145,913	0	145,913
4. Laundry	18,714	17,470	-	36,184	0	36,184	0	36,184
5. Heat and Other Utilities	-	-	111,810	111,810	0	111,810	0	111,810
6. Maintenance	36,684	9,989	22,564	69,237	0	69,237	0	69,237
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	326,658	177,732	134,875	639,265	0	639,265	-25,945	613,320
9. Medical Director	-	-	21,000	21,000	0	21,000	0	21,000
10. Nursing & Medical Records	948,453	108,555	3,205	1,060,213	0	1,060,213	0	#######
10a. Therapy	64,679	-	114,789	179,468	0	179,468	0	179,468
11. Activities	31,006	189	379	31,574	0	31,574	0	31,574
12. Social Services	38,499	-	-	38,499	0	38,499	0	38,499
13. Nurse Aide Training	-	-	-	0	0	0	0	0
14. Program Transportation	-	-	-	0	0	0	0	0
15. Other (specify)*	-	-	-	0	0	0	0	0
16. Total Health Care & Programs	#######	108,744	139,373	1,330,754	0	1,330,754	0	#######
17. Administrative	70,400	-	180,300	250,700	0	250,700	0	250,700
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	17,817	17,817	0	17,817	0	17,817
20. Fees, Subscriptions & Promotion	-	-	3,580	3,580	0	3,580	-125	3,455
21. Clerical & General Office	-	2,659	15,110	17,769	0	17,769	-99	17,670
22. Employee Benefits & Payroll	-	-	157,987	157,987	0	157,987	0	157,987
23. Inservice Training & Education	-	-	-	0	0	0	0	0
24. Travel and Seminar	-	-	-	0	0	0	0	0
25. Other Admin. Staff Trans	-	-	1,036	1,036	0	1,036	0	1,036
26. Insurance-Prop.Liab.Malpractice	-	-	46,664	46,664	0	46,664	0	46,664
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	70,400	2,659	422,494	495,553	0	495,553	-224	495,329
29. Total General Administrative	#######	289,135	696,742	2,465,572	0	2,465,572	-26,169	#######
30. Depreciation	-	-	150,994	150,994	0	150,994	-10,987	140,007
31. Amortization of Pre-Op. & Org.	-	-	12,568	12,568	0	12,568	0	12,568
32. Interest	-	-	178,232	178,232	0	178,232	-112	178,120
33. Real Estate	-	-	37	37	0	37	-37	0
34. Rent - Facility & Grounds	-	-	-	0	0	0	0	0
35. Rent - Equipment & Vehicles	-	-	52,991	52,991	0	52,991	0	52,991
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	394,822	394,822	0	394,822	-11,136	383,686
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	50,706	-	50,706	0	50,706	0	50,706
40. Barber and Beauty Shop	-	-	-	0	0	0	0	0
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	156,168	156,168	0	156,168	0	156,168
43. Other (specify):*	29,020	570	86,629	116,219	0	116,219	-116,219	0
44. Total Special Cost Ce	29,020	51,276	242,797	323,093	0	323,093	-116,219	206,874
45. Grand Total	#######	340,411	#######	3,183,487	0	3,183,487	-153,524	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	(13,522)	-13,522
2. Cash - Patient Deposits	47,211	47,211
3. Accounts & Notes Recievable	#######	1,080,568
4. Supply Inventory	13,727	13,727
5. Short-Term Investments	-	0
6. Prepaid Insurance	35,445	35,445
7. Other Prepaid Expenses	-	0
8. Accounts Receivable-Owner/Related Party	-	0
9. Other (specify):	495	495
10. Total current assets	#######	1,163,924
LONG TERM ASSETS		
11. Long-Term Notes Receivable	-	0
12. Long-Term Investments	-	0
13. Land	67,073	13,500
14. Buildings, at Historical Cost	#######	1,068,665
15. Leasehold Improvements, Historical Cost	509,932	2,350,593
16. Equipment, at Historical Cost	#######	1,204,230
17. Accumulated Depreciation (book methods)	#######	-3,866,255
18. Deferred Charges	-	0
19. Organization & Pre-Operating Costs	443,042	443,042
20. Accum Amort - Org/Pre-Op Costs	#######	-203,029
21. Restricted Funds	-	0
22. Other Long-Term Assets (specify):	-	0
23. other (specify):	339,750	339,750
24. Total Long-Term Assets	#######	1,350,496
25. Total Assets	#######	2,514,420
CURRENT LIABILITIES		
26. Accounts Payable	743,595	743,595
27. Officer's Accounts Payable	-	0
28. Accounts Payable-Patients Deposits	47,211	47,211
29. Short-Term Notes Payable	-	0
30. Accrued Salaries Payable	110,239	110,239
31. Accrued Taxes Payable	8,014	8,014
32. Accrued Real Estate Taxes	-	0
33. Accrued Interest Payable	58,890	58,890
34. Deferred Compensation	-	0
35. Federal and State Income Taxes	17,158	17,158
36. Other Current Liabilities (specify):	5,233	5,233
37. Other Current Liabilities (specify):	#######	1,632,137
38. Total Current Liabilities	#######	2,622,477
LONG TERM LIABILITES		
39.Long-Term Notes Payable	-	0
40.Mortgage Payable	#######	2,868,366
41.Bonds Payable	-	0
42.Deferred Compensation	-	0
43.Other Long-Term Liabilities (specify):	351,000	351,000
44.Other Long-Term Liabilities (specify):	-	0
45.Total Long-Term Liabilities	#######	3,219,366
46.Total Liabilities	#######	5,841,843
47.Total Equity	#######	-3,327,423
48.Total Liabilities and Equity	#######	2,514,420

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,562,824
2. Discounts and Allowances for all Levels	(196,871)
Subtotal - Inpatient Care	2,365,953
4. Day Care	-
5. Other Care for Outpatients	-
6. Therapy	214,224
7. Oxygen	896
Subtotal - Anciliary Revenue	215,120
9. Payments for Education	-
10. Other Governmental Grants	-
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	-
13. Barber and Beauty Care	-
14. Non-Patient Meals	6,672
15. Telephone, Television, and Radio	-
16. Rental of Facility Space	-
17. Sale of Drugs	88,669
18. Sale of Supplies to Non-Patients	-
19. Laboratory	-
20. Radiologyand X-Ray	6,750
21. Other Medical Services	19,693
22. Laundry	4,095
Subtotal - Other Operating Revenue	125,879
24. Contributions	-
25. Interest and Other Investments Income	112
Subtotal - Non-Operating Revenue	112
27. Other Revenue (specify):	-
28. Other Revenue (specify):	19,372
Subtotal - Other Revenue	19,372
30. Total Revenue	2,726,436
31. General Services	659,815
32. Health Care	1,494,573
33. General Administration	527,936
34. Ownership	412,842
35. Special Cost Centers	126,496
35. Provider Participation Fee	165,011
37. Other	-
40. Total Expenses	3,386,673
41. Income Before Income Taxes	(660,237)
42. Income Taxes	-
43. Net Income or Loss for the Year	(660,237)