FOR BHF USE

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

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

County: Christian

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	17,640	2,694	1,020	21,354	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,640	2,694	1,020	21,354	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.72%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 3/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 944

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	149,107	19,440	469	169,016		169,016		169,016			1
2	Food Purchase		148,895		148,895		148,895	(5,819)	143,076			2
3	Housekeeping	130,025	18,350		148,375		148,375		148,375			3
4	Laundry	20,453	11,022		31,475		31,475		31,475			4
5	Heat and Other Utilities			106,656	106,656		106,656		106,656			5
6	Maintenance	38,959	6,169	20,765	65,893		65,893		65,893			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	338,544	203,876	127,890	670,310		670,310	(5,819)	664,491			8
	B. Health Care and Programs											
9	Medical Director			20,500	20,500		20,500		20,500			9
10	Nursing and Medical Records	953,192	86,215	16,264	1,055,671		1,055,671	(91)	1,055,580			10
10a	Therapy			148,034	148,034		148,034		148,034			10a
11	Activities	34,012	560	932	35,504		35,504	(5,760)	29,744			11
12	Social Services	42,245			42,245		42,245		42,245			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,029,449	86,775	185,730	1,301,954		1,301,954	(5,851)	1,296,103			16
	C. General Administration											
17	Administrative	68,346		201,854	270,200		270,200		270,200			17
18	Directors Fees											18
19	Professional Services			11,679	11,679		11,679		11,679			19
20	Dues, Fees, Subscriptions & Promotions			2,039	2,039		2,039	(150)	1,889			20
21	Clerical & General Office Expenses	43,900	2,516	13,436	59,852		59,852	(22)	59,830			21
22	Employee Benefits & Payroll Taxes			143,090	143,090		143,090		143,090			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,804	4,804		4,804		4,804			25
26	Insurance-Prop.Liab.Malpractice			49,344	49,344		49,344		49,344			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	112,246	2,516	426,246	541,008		541,008	(172)	540,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,480,239	293,167	739,866	2,513,272		2,513,272	(11,842)	2,501,430			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie Rose Health Care Center #0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			94,985	94,985		94,985	(19,584)	75,401			30
31	Amortization of Pre-Op. & Org.			12,568	12,568		12,568		12,568			31
32	Interest			168,290	168,290		168,290	(2,690)	165,600			32
33	Real Estate Taxes			48	48		48	(48)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,683	17,683		17,683		17,683			35
36	Other (specify):*											36
37	**TOTAL Ownership**			293,574	293,574		293,574	(22,322)	271,252			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,974		24,974		24,974		24,974			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,714	180,714		180,714		180,714			42
43	Other (specify):* Miscellaneous	34,127	2,132	45,410	81,669		81,669	(81,669)				43
44	**TOTAL Special Cost Centers**	34,127	27,106	226,124	287,357		287,357	(81,669)	205,688			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,514,366	320,273	1,259,564	3,094,203		3,094,203	(115,833)	2,978,370			45

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,819)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,897)	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	(19,584)	30		9
10	Interest and Other Investment Income	(2,690)	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	(36,588)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,767)	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	(45,488)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (115,833)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,833)		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 Center

ID# 0045245

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,469)	43	1
2	X-Rays-Part A	(1,933)	43	2
3	Pet Expense	(808)	43	3
4	Disallowed R.E. Taxes	(48)	33	4
5	Miscellaneous Revenue Offset-Nursing Supplies	(91)	10	5
6	Disallowed Marketing Expense	(34,127)	43	6
7	Disallowed Special Events	(49)	43	7
8	Disallowed Chamber of Commerce Dues	(150)	20	8
9	Transportation Revenue Offset	(5,760)	11	9
10	Miscellaneous Revenue Offset-Office Supplies	(22)	21	10
11	Resident Flowers	(31)	43	11
12				12
13				13
14				14
15				15
16				16
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35				35
36				36
37				37
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(45,488)		49

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	See PG6-Supp		See PG6-Supp		

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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care `	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care `	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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29								29
30								30

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

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

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1									$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Wells Fargo		X	Mortgage	$21,167.65	12/01/02	$ 3,580,869	$ 2,768,896	11/01/35	0.0618	$ 168,290	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	$ 2,768,896			$ 168,290	9
	B. Non-Facility Related*											
10								Interest Income Offset			(2,690)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,690)	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 2,768,896			$ 165,600	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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	48	2
3. Under or (over) accrual (line 2 minus line 1).	$	48	3
4. Real Estate Tax accrual used for 2018 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**		(48)	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	31	8
	2014	34	9
	2015	37	10
	2016	42	11
	2017	48	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-25-21-401-010-00	Land	$ 47.58	$ 47.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47.58	$ 47.58

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 _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 848,992	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986-1997 Additions				1,616,776					1,616,776	9
10	Whirlpool Bath			1998	9,120		10			9,120	10
11	Lift, Bath Trolley			1998	3,850		10			3,850	11
12	Shower Room			1998	4,884		10			4,884	12
13	Entrance Doors			1998	2,358		20	87	87	2,358	13
14	Curtains			1998	6,102		5			6,102	14
15	Sidewalk & Pad			1999	1,484		15			1,484	15
16	Divide Receipts on Emergency Generator			1999	2,397		20	120	120	2,339	16
17	Med Room Cabinets and Counter Top			1999	2,008		20	100	100	1,904	17
18	Door Alarms			2001	1,215		15			1,215	18
19	Dining Room, Living Room, Shower Remodel			2001	94,315		30	3,144	3,144	55,281	19
20	Wooded Doors			2001	1,900		15			1,900	20
21	Landscaping-Renovation Project			2001	1,174		10			1,174	21
22	Bituminous Parking Lot			2001	22,030		8			22,030	22
23	Replace Plumbing Fixtures			2002	$ 2,490	$	20	$ 125	125	2,122	23
24	Therapy Room Remodel			2002	5,617		20	281	281	4,636	24
25	Remodel Medication/Utility Rooms			2002	7,909		20	395	395	6,520	25
26	Breakroom Remodel			2002	3,106		10			3,106	26
27	Exterior Window Covering			2002	7,650		7			7,650	27
28	Lights for Therapy Room			2002	805		10			805	28
29	Renovation on Facility Floors and Walls			2002	36,842		20	1,842	1,842	29,626	29
30	Fire Supression System			2004	1,540		10			1,540	30
31	Antenna			2004	2,944		10			2,944	31
32	Sign			2004	1,200		10			1,200	32
33	Carpet			2005	1,281		5			1,281	33
34	Sidewalks			2006	8,735		10			8,735	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Duct Work	2007	5,120		15	342	$ 342	$ 3,933	37
38	Sidewalks	2007	8,976		15	598	598	6,877	38
39	Water Heater & Duct Work	2008	4,850		10	242	242	4,850	39
40	Air Conditioner-Rooftop	2008	9,120		10	912	912	6,486	40
41	Plumbing Repair	2008	3,442		10			3,442	41
42	Ceramic Tile Replacement	2008	9,996		20	500	500	5,250	42
43	Vinyl Tile Replacement	2008	4,495		20	225	225	2,475	43
44	Sidwalk Marquee	2008	4,985		10	245	245	4,985	44
45	Generator Repair	2008	2,562		10	130	130	2,562	45
46	Dementia Unit Remodeling-Architect and Engineering	2008	14,466		20	724	724	7,602	46
47	Dementia Unit Remodeling-Demolition, Doors and Windows	2008	13,168		20	658	658	6,909	47
48	Dementia Unit Remodeling-Drywall and Hand Railings	2008	25,343		20	1,268	1,268	13,314	48
49	Dementia Unit Remodeling-Drywall and Hand Railings	2008	10,796		20	540	540	5,670	49
50	Dementia Unit Remodeling-Drywall, Painting, and Electrical	2008	20,841		20	1,042	1,042	10,941	50
51	Dementia Unit Remodeling-Carpeting & Flooring	2008	29,889		20	1,494	1,494	15,687	51
52	Tiling for Bathroom	2009	13,519		15	902	902	8,569	52
53	Generator Repair	2009	3,984		7			3,984	53
54	Air Conditioner-Rooftop	2009	10,281		15	686	686	1,517	54
55	Wandering Patient Alarm System	2010	5,050		7			5,050	55
56	Sprinkler System Repair	2009	33,658		10			25,245	56
57	Water Heater	2011	3,356		7	236	236	3,356	57
58	Fire Alarm Control Installation	2012	2,958		7	422	422	2,743	58
59	Landscaping	2013	10,158		15	678	678	3,729	59
60	Parking Lot Repair	2013	2,500		7	358	358	1,969	60
61	Water Pipe Repair	2014	7,170		7	1,024	1,024	4,608	61
62	Gutters and Soft	2014	7,936		25	317	317	1,427	62
63	Patio Replacement	2014	9,592		15	640	640	2,880	63
64	Roof Replacement	2015	222,650		25	8,906	8,906	31,171	64
65									65
66	Land Improvements Booked			1,633			(1,633)		66
67	Building Improvement Booked			87,292			(87,292)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,419,258	$ 88,925		$ 64,805	$ (24,120)	$ 2,846,805	70

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 121,555	$ 5,648	$ 10,390	$ 4,742	5-10 yrs.	$ 100,458	71
72	Current Year Purchases	2,882	412	206	(206)	7 yrs.	206	72
73	Fully Depreciated Assets	1,082,675					1,082,675	73
74	Home Office Allocation							74
75	TOTALS	$ 1,207,112	$ 6,060	$ 10,596	$ 4,536		$ 1,183,339	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)	$ 4,639,870	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 94,985	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,401	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,584)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,030,144	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	N/A				87
88					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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 17,683 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					17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	9,736
Dishwasher		660
Copier		7,287
Home Office Allocation		-
		17,683

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	3,553	$	53,298	$	3,553	$ 53,298	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,306		34,585		2,306	34,585	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs		4,003		60,048		4,003	60,048	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					24,974		24,974	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): Rehabilative Therapy				7		103		7	103	13
14	TOTAL			$	9,869	$	148,034	$ 24,974	9,869	$ 173,008	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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 134,817	$ 134,817	1
2	Cash-Patient Deposits	44,273	44,273	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,024)	1,427,022	1,427,022	3
4	Supply Inventory (priced at Cost)	13,727	13,727	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,095	24,095	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,643,934	$ 1,643,934	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	1,207,112	1,207,112	16
17	Accumulated Depreciation (book methods)	(3,873,694)	(4,030,144)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	443,042	443,042	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(228,166)	(228,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Escrows and Reserves	397,064	397,064	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,364,572	$ 1,221,666	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,008,506	$ 2,865,600	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 693,612	$ 693,612	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,273	44,273	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,603	117,603	30
31	Accrued Taxes Payable (excluding real estate taxes)	217,258	217,258	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	182,550	182,550	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	143,961	143,961	35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,580	1,580	36
37	Accrued Management Fees	1,065,832	1,065,832	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,466,669	$ 2,466,669	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,768,896	2,768,896	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)**	$ 3,119,896	$ 3,119,896	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,586,565	$ 5,586,565	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,578,059)	$ (2,720,965)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,008,506	$ 2,865,600	48

***(See instructions.)**

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,622,760)	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)**	$ (2,622,763)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	44,704	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)**	$ 44,704	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)**	$ (2,578,059)	24 *

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

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,906,097	1
2	Discounts and Allowances for all Levels	(104,843)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,801,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,226	6
7	Oxygen	761	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 264,987	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	5,819	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	43,564	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,377	20
21	Other Medical Services	9,343	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 64,103	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,690	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,690	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	5,760	28
28a	Miscellaneous Revenue	113	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,873	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,138,907	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	670,310	31
32	Health Care	1,301,954	32
33	General Administration	541,008	33
	B. Capital Expense		
34	Ownership	293,574	34
	C. Ancillary Expense		
35	Special Cost Centers	106,643	35
36	Provider Participation Fee	180,714	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,094,203	40
41	**Income before Income Taxes (line 30 minus line 40)****	44,704	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 44,704	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,237,858	44
45	Private Pay - Net Inpatient Revenue	346,517	45
46	Medicare - Net Inpatient Revenue	207,359	46
47	Other-(specify) Insurance Net Inpatient Revenue	9,520	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,801,254	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 Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			$ 55,833	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses			32,437		3
4	Licensed Practical Nurses			327,479		4
5	CNAs & Orderlies			478,033		5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director			25,853		9
10	Activity Assistants			7,315		10
11	Social Service Workers			42,245		11
12	Dietician					12
13	Food Service Supervisor			28,755		13
14	Head Cook					14
15	Cook Helpers/Assistants			120,352		15
16	Dishwashers					16
17	Maintenance Workers			38,959		17
18	Housekeepers			130,025		18
19	Laundry			20,453		19
20	Administrator	2,176	2,176	68,346	31.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager			43,900		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) Page 20A	1	1	94,381	#######	33
34	TOTAL (lines 1 - 33)	2,177	2,177	$ 1,514,366 *	$ 695.62	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	Monthly	$ 469	L1, C3	35
36	Medical Director	Monthly	20,500	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,957	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)		$ 26,926		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	141	4,552	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	141	$ 4,552		53

Prairie Rose Health Care Center
0045245
Period Beginning **1/1/2018**
Period End **12/31/2018**

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	1	26,147	#######
Alzheimer's Coordinator			33,263	#DIV/0!
Transportation			844	#DIV/0!
Marketing			34,127	#DIV/0!
TOTAL	1	1	94,381	

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Moore	Administrator	0	$ 3,347
Ashlie Schmitz	Administrator	0	64,999
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,346

B. Administrative - Other

Description	Amount
Management Fees	$ 201,854
TOTAL (agree to Schedule V, line 17, col. 3)	$ 201,854
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
UMB Bank	Legal Fees	$ 2,915
Consolidated Communications	Computer Services	662
Allscripts	Computer Services	444
Ability Network	Computer Services	1,073
Brighthouse Financial	Legal Fees	15
Ginoli and Company	Accounting Fees	6,570
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 11,679

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,090
Unemployment Compensation Insurance	
FICA Taxes	108,888
Employee Health Insurance	362
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,407
Employee Retirement	1,343
TOTAL (agree to Schedule V, line 22, col.8)	$ 143,090

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	126
Health Care Worker Background Check	
(Indicate # of checks performed 11)	330
Patient Background Checks	696
Miscellaneous Licenses & Permits	737
Miscellaneous Dues & Subscriptions	150
Less: Public Relations Expense	(150)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,889

G. Schedule of Travel and Seminar**

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

**See instructions.

Prairie Rose Health Care Center
0045245
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

25. Administrative and Staff Transportation

Gas	$	3,067
Auto Repairs		807
Mileage-Travel		930
Home Office Allocation		-
		4,804

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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-**

(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. $ **20,803** 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. $ **180,714**
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. $ **5,619**

(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. $ **5,760**
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** **01:26 PM** **7/25/2019**

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	-115,833	equal to	-115,833	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	165,600	equal to	165,600	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening	12,568	equal to	12,568	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	75,401	equal to	75,401	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	17,683	equal to	17,683	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	148,034	equal to	148,034	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	24,974	equal to	24,974	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	670,310	equal to	670,310	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,301,954	equal to	1,301,954	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	541,008	equal to	541,008	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	293,574	equal to	293,574	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	106,643	equal to	106,643	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	180,714	equal to	180,714	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	953,192	equal to	953,192	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	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	34,012	equal to	34,012	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	42,245	equal to	42,245	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	149,107	equal to	149,107	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	38,959	equal to	38,959	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	130,025	equal to	130,025	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	20,453	equal to	20,453	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	68,346	equal to	68,346	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	43,900	equal to	43,900	0	O.K.	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	1,514,366	equal to	1,514,366	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	469	< or = to	469	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	20,500	< or = to	20,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	10,509	< or = to	16,264	-5,755	O.K.	Pg20 X14..X16	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	932	-932	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.	68,346	equal to	68,346	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	201,854	equal to	201,854	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	11,679	equal to	11,679	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	143,090	equal to	143,090	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	1,889	equal to	1,889	0	O.K.	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	180,714	equal to	180,714	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	944	equal to	1,020	-76	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. cos	0	equal to	#VALUE!	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,768,896	equal to	2,768,896	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	1,207,112	equal to	1,207,112	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,030,144	equal to	4,030,144	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-2,578,059	equal to	-2,578,059	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	44,704	equal to	44,704	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. co	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,008,506	equal to	3,008,506	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!!!!** 7/25/2019 01:26:25 PM

HSA Number:	4	Name:	Prairie Rose Health Care Center		
Cost report peri From:	1/1/2018	To:	12/31/2018	Base Number:	516
If this is an ICF/DD 16 facility, e	N				
Licensed bed d	38,325	Occupancy:	21,354	Pct. of occupan	55.72%
ublic Aid Support Rate:		$ ______			
Genl Services S	338,544	Col 1, Line 8 ---Audit Adj:	______		
Genl Admin Sal	112,246	Col 1, Line 28 ---Audit Adj:	______		
Total Salary Wa	1,514,366	Col 1, Line 44 ---Audit Adj:	______		
Employee Bene	143,090	Col 8, Line 22 ---Audit Adj:	______		
Total General S	664,491	Col 8, Line 8 ---Audit Adj:	______		
Total General A	540,836	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)	$338,544
Divided by Total Wages (Column 1, Line 44)	$1,514,366
General service wages as percent of total wages	22.3555%
Employee Benefits (Column 10, Line 22)	$143,090
Allocation of Employee Benefits to General Services Costs	$31,988
Plus Total General Services (Column 10, Line 8)	$664,491
New Total General Services Cost	$696,479

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).	$112,246
Divided by Total Wages (Column 1, Line 45)	$1,514,366
General administration wages as a percent of total wages	7.4121%
Employee Benefits (Column 10, Line 22)	$143,090
Allocation of Employee Benefits to General Admin. Costs	$10,606
Plus Total General Administration (Column 10, Line 28)	$540,836
Minus Total Fringe (Column 10, Line 22)	$143,090
New Total General Administration Cost	$408,352

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	236 multiplied by 6 =	1416
Sum of the three lines		1423.026316
Subtract from the sum		907.00
Base Number (expressed as a whole number, fraction dropped)		516

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)	$696,479	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$696,479

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)	$408,352	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$408,352
3 Total Updated Support Costs (1 + 2)		$1,104,831

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 $42.30

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)	$1,104,831
Total Patient Days (Cost Report)	21,354
Support Costs per Diem	$51.74

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	21,354
	14,288
One-third of difference	4,763
Plus Total Patient Days	21,354
Adjusted Occupancy	26,117
Total Support Costs (Step II, C, 3, above)	$1,104,831
Divided by Adjusted Occupany	26117
Support Costs Per Diem	$42.30

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	$42.30
Difference	$5.14
Multiply the Difference by	0.5
One-Half of the Difference	$2.57
Plus Support Costs Per Diem	$42.30
Support Rate if costs are between 35th and 75th percentile	44.87

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	$42.30
Difference	$5.14
Multiply the Difference by	0.5
One-Half of the Difference	$2.57
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	$2.570
Plus Support Costs Per Diem	$42.30
Support Rate if support costs less than 35th percentile	$44.87

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$44.87**

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	149,107	19,440	469	169,016	0	169,016	0	169,016
2. Food Purchase	-	148,895	-	148,895	0	148,895	-5,819	143,076
3. Housekeeping	130,025	18,350	-	148,375	0	148,375	0	148,375
4. Laundry	20,453	11,022	-	31,475	0	31,475	0	31,475
5. Heat and Other Utilities	-	-	106,656	106,656	0	106,656	0	106,656
6. Maintenance	38,959	6,169	20,765	65,893	0	65,893	0	65,893
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	338,544	203,876	127,890	670,310	0	670,310	-5,819	664,491
9. Medical Director	-	-	20,500	20,500	0	20,500	0	20,500
10. Nursing & Medical Records	953,192	86,215	16,264	1,055,671	0	1,055,671	-91	#######
10a. Therapy	-	-	148,034	148,034	0	148,034	0	148,034
11. Activities	34,012	560	932	35,504	0	35,504	-5,760	29,744
12. Social Services	42,245	-	-	42,245	0	42,245	0	42,245
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	#######	86,775	185,730	1,301,954	0	1,301,954	-5,851	#######
17. Administrative	68,346	-	201,854	270,200	0	270,200	0	270,200
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	11,679	11,679	0	11,679	0	11,679
20. Fees, Subscriptions & Promotion	-	-	2,039	2,039	0	2,039	-150	1,889
21. Clerical & General Office	43,900	2,516	13,436	59,852	0	59,852	-22	59,830
22. Employee Benefits & Payroll	-	-	143,090	143,090	0	143,090	0	143,090
23. Inservice Training & Education	-	-	-	0	0	0	0	0
24. Travel and Seminar	-	-	-	0	0	0	0	0
25. Other Admin. Staff Trans	-	-	4,804	4,804	0	4,804	0	4,804
26. Insurance-Prop.Liab.Malpractice	-	-	49,344	49,344	0	49,344	0	49,344
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	112,246	2,516	426,246	541,008	0	541,008	-172	540,836
29. Total General Administrative	#######	293,167	739,866	2,513,272	0	2,513,272	-11,842	#######
30. Depreciation	-	-	94,985	94,985	0	94,985	-19,584	75,401
31. Amortization of Pre-Op. & Org.	-	-	12,568	12,568	0	12,568	0	12,568
32. Interest	-	-	168,290	168,290	0	168,290	-2,690	165,600
33. Real Estate	-	-	48	48	0	48	-48	0
34. Rent - Facility & Grounds	-	-	-	0	0	0	0	0
35. Rent - Equipment & Vehicles	-	-	17,683	17,683	0	17,683	0	17,683
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	293,574	293,574	0	293,574	-22,322	271,252
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	24,974	-	24,974	0	24,974	0	24,974
40. Barber and Beauty Shop	-	-	-	0	0	0	0	0
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	180,714	180,714	0	180,714	0	180,714
43. Other (specify):*	34,127	2,132	45,410	81,669	0	81,669	-81,669	0
44. Total Special Cost Ce	34,127	27,106	226,124	287,357	0	287,357	-81,669	205,688
45. Grand Total	#######	320,273	#######	3,094,203	0	3,094,203	-115,833	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	134,817	134,817
2. Cash - Patient Deposits	44,273	44,273
3. Accounts & Notes Recievable	#######	1,427,022
4. Supply Inventory	13,727	13,727
5. Short-Term Investments	-	0
6. Prepaid Insurance	24,095	24,095
7. Other Prepaid Expenses	-	0
8. Accounts Receivable-Owner/Related Party	-	0
9. Other (specify):	-	0
10. Total current assets	#######	1,643,934
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	#######	1,207,112
17. Accumulated Depreciation (book methods)	#######	-4,030,144
18. Deferred Charges	-	0
19. Organization & Pre-Operating Costs	443,042	443,042
20. Accum Amort - Org/Pre-Op Costs	#######	-228,166
21. Restricted Funds	-	0
22. Other Long-Term Assets (specify):	-	0
23. other (specify):	397,064	397,064
24. Total Long-Term Assets	#######	1,221,666
25. Total Assets	#######	2,865,600
CURRENT LIABILITIES		
26. Accounts Payable	693,612	693,612
27. Officer's Accounts Payable	-	0
28. Accounts Payable-Patients Deposits	44,273	44,273
29. Short-Term Notes Payable	-	0
30. Accrued Salaries Payable	117,603	117,603
31. Accrued Taxes Payable	217,258	217,258
32. Accrued Real Estate Taxes	-	0
33. Accrued Interest Payable	182,550	182,550
34. Deferred Compensation	-	0
35. Federal and State Income Taxes	143,961	143,961
36. Other Current Liabilities (specify):	1,580	1,580
37. Other Current Liabilities (specify):	#######	1,065,832
38. Total Current Liabilities	#######	2,466,669
LONG TERM LIABILITES		
39.Long-Term Notes Payable	-	0
40.Mortgage Payable	#######	2,768,896
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	#######	3,119,896
46.Total Liabilities	#######	5,586,565
47.Total Equity	#######	-2,720,965
48.Total Liabilities and Equity	#######	2,865,600

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,906,097
2. Discounts and Allowances for all Levels	(104,843)
Subtotal - Inpatient Care	2,801,254
4. Day Care	-
5. Other Care for Outpatients	-
6. Therapy	264,226
7. Oxygen	761
Subtotal - Anciliary Revenue	264,987
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	5,819
15. Telephone, Television, and Radio	-
16. Rental of Facility Space	-
17. Sale of Drugs	43,564
18. Sale of Supplies to Non-Patients	-
19. Laboratory	-
20. Radiologyand X-Ray	5,377
21. Other Medical Services	9,343
22. Laundry	-
Subtotal - Other Operating Revenue	64,103
24. Contributions	-
25. Interest and Other Investments Income	2,690
Subtotal - Non-Operating Revenue	2,690
27. Other Revenue (specify):	5,760
28. Other Revenue (specify):	113
Subtotal - Other Revenue	5,873
30. Total Revenue	3,138,907
31. General Services	635,202
32. Health Care	1,198,349
33. General Administration	527,072
34. Ownership	345,737
35. Special Cost Centers	68,780
35. Provider Participation Fee	160,906
37. Other	-
40. Total Expenses	2,936,046
41. Income Before Income Taxes	202,861
42. Income Taxes	-
43. Net Income or Loss for the Year	202,861