		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

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 Facility ID Number: 0012922

Facility Name: PRAIRIE VIEW HEALTHCARE

Address: 16827 1410 North Avenue (Number) Princeton (City) 61356 (Zip Code)

County: Bureau

Telephone Number: (815)875-1196 **Fax #** (815)872-4408

IDPA ID Number: 366006533001

Date of Initial License for Current Owners: 00/00/1961

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	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: Carla Paschal Telephone Number: (815)625-5800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/01 to 11/30/02 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)	Adrienne Erickson
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	See Independent Auditor's Report attached
	(Firm Name & Address)	Clifton Gunderson LLP 3917 East Lincolnway, Suite A, Sterling, IL 61081
	(Telephone)	(815)625-5800 Fax # (815)626-4386

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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 12/17/01 and 7/10/02

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	75	27,583	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	48	19,983	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	123	47,566	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			2,728	2,728	8
9	SNF/PED					9
10	ICF	28,006	6,203		34,209	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,006	6,203	2,728	36,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.65%

D. How many bed-hold days during this year were paid by Public Aid?
0 (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 1961

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 2,755

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A Fiscal Year: 11/30/02

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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 OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,945	19,207	9,769	229,921		229,921		229,921			1
2	Food Purchase		152,039		152,039		152,039		152,039			2
3	Housekeeping	101,729	10,208	4,488	116,425		116,425		116,425			3
4	Laundry	77,785	17,666		95,451		95,451		95,451			4
5	Heat and Other Utilities			80,322	80,322		80,322		80,322			5
6	Maintenance	61,293	8,338	41,473	111,104		111,104		111,104			6
7	Other (specify):* Admissions/Mktg	25,500			25,500		25,500		25,500			7
8	TOTAL General Services	467,252	207,458	136,052	810,762		810,762		810,762			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,458,811	120,483	267,294	1,846,588		1,846,588		1,846,588			10
10a	Therapy	57,518	3,331	55,638	116,487		116,487		116,487			10a
11	Activities	44,570	1,941	2,279	48,790		48,790		48,790			11
12	Social Services	43,428		17,246	60,674		60,674		60,674			12
13	Nurse Aide Training	9,318	662	11,916	21,896		21,896		21,896			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,613,645	126,417	354,373	2,094,435		2,094,435		2,094,435			16
	C. General Administration											
17	Administrative	60,000			60,000		60,000		60,000			17
18	Directors Fees			3,500	3,500		3,500		3,500			18
19	Professional Services			100,005	100,005		100,005		100,005			19
20	Dues, Fees, Subscriptions & Promotions			35,009	35,009		35,009	(28,519)	6,490			20
21	Clerical & General Office Expenses	87,153	10,348	30,542	128,043		128,043	(8,842)	119,201			21
22	Employee Benefits & Payroll Taxes			458,992	458,992		458,992		458,992			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,831	3,831		3,831		3,831			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,164	90,164		90,164		90,164			26
27	Other (specify):*							2,216	2,216			27
28	TOTAL General Administration	147,153	10,348	722,043	879,544		879,544	(35,145)	844,399			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,228,050	344,223	1,212,468	3,784,741		3,784,741	(35,145)	3,749,596			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 VIEW HEALTHCARE #0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,735	54,735		54,735	(2,670)	52,065			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,690	7,690		7,690		7,690			35
36	Other (specify):*											36
37	TOTAL Ownership			62,425	62,425		62,425	(2,670)	59,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			137,895	137,895		137,895		137,895			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,989	70,989		70,989		70,989			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			208,884	208,884		208,884		208,884			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,228,050	344,223	1,483,777	4,056,050		4,056,050	(37,815)	4,018,235			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 VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,670)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,519)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(19,507)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,696)		$	30

OHF 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)	12,881	21, 27	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 12,881		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (37,815)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PRAIRIE VIEW HEALTHCARE

ID# 0012922

Report Period Beginning: 12/01/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	reimbursements-resident accounts	$ (15,787)	21	1
2	reimbursements	(3,720)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,507)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	Nurse Aide 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	(28,519)	0	0	0	0	0	0	0	0	0	0	(28,519)	20
21	Clerical & General Office Expenses	(19,507)	10,665	0	0	0	0	0	0	0	0	0	(8,842)	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	2,216	0	0	0	0	0	0	0	0	0	2,216	27
28	**TOTAL General Administration**	(48,026)	12,881	0	0	0	0	0	0	0	0	0	(35,145)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,026)	12,881	0	0	0	0	0	0	0	0	0	(35,145)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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	(2,670)	0	0	0	0	0	0	0	0	0	0	(2,670)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	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**	(2,670)	0	0	0	0	0	0	0	0	0	0	(2,670)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(50,696)	12,881	0	0	0	0	0	0	0	0	0	(37,815)	45

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bureau County, Illinois	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. [X] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	County Treasurer Office	$	Bureau County, Illinois	100.00%	$ 1,616	$ 1,616	1
2	V	21	County Clerk Office		Bureau County, Illinois	100.00%	9,049	9,049	2
3	V	27	Treasurers-payroll taxes		Bureau County, Illinois	100.00%	124	124	3
4	V	27	Clerks-payroll taxes		Bureau County, Illinois	100.00%	692	692	4
5	V	27	Treasurers-health insurance		Bureau County, Illinois	100.00%	172	172	5
6	V	27	Clerks-health insurance		Bureau County, Illinois	100.00%	1,128	1,128	6
7	V	27	Treasurers-IMRF		Bureau County, Illinois	100.00%	15	15	7
8	V	27	Clerks-IMRF		Bureau County, Illinois	100.00%	85	85	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 12,881	$ * 12,881	14

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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: Bureau County
Street Address: 700 S. Main Street
City / State / Zip Code: Princeton, Illinois 61356
Phone Number: (815-872-3241
Fax Number: (815-879-4803

	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	21	County Treasurer Office	direct hours	4,160	2	$ 60,570	$ 60,570	111	$ 1,616	1
2	21	County Clerk Office	direct hours	4,160	2	51,709	51,709	728	9,049	2
3	27	Treasurers-payroll taxes	7.65% of alloc salary	4,160	2	4,634		111	124	3
4	27	Clerks-payroll taxes	7.65% of alloc salary	4,160	2	3,956		728	692	4
5	27	Treasurers-health insurance	$1.55/hour allocated	4,160	2	6,448		111	172	5
6	27	Clerks-health insurance	$1.55/hour allocated	4,160	2	6,448		728	1,128	6
7	27	Treasurers-IMRF	0.94% of alloc salary	4,160	2	569		111	15	7
8	27	Clerks-IMRF	0.94% of alloc salary	4,160	2	486		728	85	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					$ 134,819	$ 112,279		$ 12,881	25

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VIEW HEALTHCARE COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0012922

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,745 B. General Construction Type: Exterior concrete/brick Frame _____ Number of Stories three

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Adult Day Care 1,690 square feet

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	123			1961	$ 1,254,886	$	35	$	$	$ 1,254,885	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1962	11,272		20			11,272	9
10	Various			1971	2,057		20	51	51	1,635	10
11	Various			1972	2,907		20	73	73	2,261	11
12	Various			1973	934		20	23	23	701	12
13	Various			1974	1,172		20	29	29	842	13
14	Various			1975	1,207		20	30	30	841	14
15	Various			1976	4,845		20	121	121	3,278	15
16	Various			1979	34,833		20	871	871	20,904	16
17	Various			1980	11,724		20	293	293	6,739	17
18	Various			1981	123,199		20	3,080	3,080	62,825	18
19	Various			1982	108,830		20	2,721	2,721	59,273	19
20	Various			1983	33,664		20	842	842	16,833	20
21	Various			1984	18,550		20	928	928	17,632	21
22	Various			1985	26,319		20	1,316	1,316	23,688	22
23	Various			1987	5,075		20	254	254	4,061	23
24	Various			1988	13,173		20	659	659	9,885	24
25	Various			1989	51,234		20	2,562	2,562	35,868	25
26	Various			1990	16,786		20	839	839	10,907	26
27	Various			1992	24,562		20	1,229	1,229	12,904	27
28	Various			1993	35,494		20	3,417	3,417	24,249	28
29	Various			1995	114,757		20	6,013	6,013	43,389	29
30	Various			1996	11,479		20	662	662	3,997	30
31	Various			1997	11,369		20	596	596	2,792	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			54,735			(54,735)		69
70	TOTAL (lines 4 thru 69)		$ 1,920,328	$ 54,735		$ 26,609	$ (28,126)	$ 1,631,661	70

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,920,328	$ 54,735		$ 26,609	$ (28,126)	$ 1,631,661	1
2	BUILDING IMPROVEMENTS	1998	1,523		20	152	152	608	2
3	SIGNS	1999	1,046		20	105	105	328	3
4	OUTSIDE POLES-PAINT	1999	1,134		20	113	113	348	4
5	SIGNS	1999	2,061		20	206	206	635	5
6	SINKS	2000	1,656		20	76	76	228	6
7	ALARM SYSTEM	2000	6,068		20	506	506	1,518	7
8	WALK-IN COOLER-COMPRESSOR	2000	1,018		20	45	45	135	8
9	ROOM REMODELING	2000	620		20	83	83	249	9
10	STERLING BORDERS	2000	540		20	72	72	216	10
11	WALLPAPER	2000	945		20	79	79	237	11
12	WALLPAPER	2000	524		20	35	35	105	12
13	WALK-IN COOLER REPAIRS	2000	666		20	11	11	33	13
14	STERLING TEXTURE DRAPES	2000	1,694		20	283	283	849	14
15	REMOVE DOORS AND TOILETS IN ALZHEIMERS UNIT	2000	14,183		20	50	50	150	15
16	PARKING LOT	2000	3,595		20	90	90	270	16
17	EVAPORATOR MOTOR	2000	980		20	49	49	98	17
18	SINGLE DOOR CODE LOCK	2001	824		20	69	69	138	18
19	WALK IN FREEZER REPAIRS	2001	922		20	20	20	40	19
20	ROOF FOR PUMP HOUSE	2001	2,310		20	39	39	78	20
21	FENCING-ALZHEIMERS UNIT	2001	7,192		20	160	160	320	21
22	GUTTER & DOWNSPOUT	2001	1,100		20	28	28	56	22
23	BOILER	2001	5,718		20	127	127	254	23
24	ROOF REPAIRS	2001	3,450		20	115	115	230	24
25	DISHWASHER	2001	14,624		20	122	122	244	25
26	GATE	2001	500		20	4	4	8	26
27	PUMPHOUSE ROOF	2001	2,310		20	29	29	58	27
28	ROOF	2001	3,450		20	108	108	216	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,000,981	$ 54,735		$ 29,385	$ (25,350)	$ 1,639,310	34

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 196,050	$	$ 19,605	$ 19,605	10	$ 87,983	71
72	Current Year Purchases	19,748		1,975	1,975	10	1,975	72
73	Fully Depreciated Assets	405,302				10	405,302	73
74								74
75	TOTALS	$ 621,100	$	$ 21,580	$ 21,580		$ 495,260	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	transport residents	Van	2002	$ 5,500	$	$ 1,100	$ 1,100	5	$ 1,100	76
77										77
78										78
79										79
80	TOTALS			$ 5,500	$	$ 1,100	$ 1,100		$ 1,100	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)	$ 2,627,581	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,735	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,065	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,670)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,135,670	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					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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 Date of Lease	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.	/2003	$
13.	/2004	$
14.	/2005	$

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: $ 7,690 Description: $5840 copier rental and $1850 oxygen tank rentals
(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.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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

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

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	102

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 392	$ 4,451	$	$ 4,843
2	Books and Supplies		662		662
3	Classroom Wages (a)	439	9,547		9,986
4	Clinical Wages (b)	267	5,588		5,855
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	$ 1,098	$ 20,798	$	$ 21,896
10	SUM OF line 9, col. 1 and 2 (e)	$ 21,896			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	12

(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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 56,912	$		$ 56,912	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			3,781			3,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			77,202			77,202	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 137,895	$		$ 137,895	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (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	$ 5,036	$	1
2	Cash-Patient Deposits	14,557		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	656,574		3
4	Supply Inventory (priced at)	6,761		4
5	Short-Term Investments			5
6	Prepaid Insurance			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)**	$ 682,928	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,254,886		14
15	Leasehold Improvements, at Historical Cost	691,226		15
16	Equipment, at Historical Cost	609,337		16
17	Accumulated Depreciation (book methods)	(2,120,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 434,527	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,117,455	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 230,464	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,556		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,324		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other funds	2,149,643		36
37	Compensated Absences	30,572		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,460,559	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,460,559	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,343,104)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,117,455	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,539,973)	1
2	Restatements (describe):		2
3	Equity Adjustment-correction to prior year accts receivable	63,164	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,476,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	133,705	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)**	$ 133,705	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,343,104)	24 *

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

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,847,712	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,847,712	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	10,093	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,093	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see attached schedule	331,950	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 331,950	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,189,755	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	810,762	31
32	Health Care	2,094,435	32
33	General Administration	879,544	33
	B. Capital Expense		
34	Ownership	62,425	34
	C. Ancillary Expense		
35	Special Cost Centers	137,895	35
36	Provider Participation Fee	70,989	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,056,050	40
41	**Income before Income Taxes (line 30 minus line 40)****	133,705	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 133,705	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,821	1,889	$ 50,760	$ 26.87	1
2	Assistant Director of Nursing	938	975	25,374	26.02	2
3	Registered Nurses	5,743	5,871	119,801	20.41	3
4	Licensed Practical Nurses	15,856	16,318	258,780	15.86	4
5	Nurse Aides & Orderlies	76,817	78,973	878,828	11.13	5
6	Nurse Aide Trainees	1,762	1,762	9,318	5.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,138	4,443	57,518	12.95	8
9	Activity Director	1,913	1,950	20,124	10.32	9
10	Activity Assistants	3,372	3,664	24,446	6.67	10
11	Social Service Workers	4,613	4,736	43,428	9.17	11
12	Dietician					12
13	Food Service Supervisor	1,913	1,950	26,733	13.71	13
14	Head Cook	6,258	6,751	57,204	8.47	14
15	Cook Helpers/Assistants	10,754	11,270	70,975	6.30	15
16	Dishwashers	5,282	5,848	46,033	7.87	16
17	Maintenance Workers	5,041	5,341	61,293	11.48	17
18	Housekeepers	12,801	13,763	101,729	7.39	18
19	Laundry	9,563	10,283	77,785	7.56	19
20	Administrator	1,913	1,950	60,000	30.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,898	2,010	29,533	14.69	23
24	Clerical	4,828	5,095	39,420	7.74	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	2,871	3,163	29,236	9.24	31
32	Other Health Care(specify)					32
33	Other(specify) see attach detail	13,743	14,032	139,732	9.96	33
34	TOTAL (lines 1 - 33)	193,838	202,037	$ 2,228,050 *	$ 11.03	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	176	$ 7,133	1-03	35
36	Medical Director				36
37	Medical Records Consultant	evry othr mth	2,400	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,400	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	3,053	11-03	44
45	Social Service Consultant	49	3,128	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	$ 18,114		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,491	$ 134,980	10-03	50
51	Licensed Practical Nurses	3,730	128,208	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7,221	$ 263,188		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adrienne Erickson	Administrator		$ 60,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,000

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Patricia Pratt	Medicare Consultant	$ 4,163
Computer Medic	Computer Assistance	2,287
Frost,Ruttenberg&Rothblatt	Accounting	87,915
Accumed	Software Support	5,640
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 100,005

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	12,571
FICA Taxes	165,331
Employee Health Insurance	257,231
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	23,815
PV Employee Fund	44
TOTAL (agree to Schedule V, line 22, col.8)	$ 458,992

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,998
Health Care Worker Background Check (Indicate # of checks performed 41)	492
Advertising	971
Subscriptions	
Classified Advertising	
Fundraising	7,443
Public Relations	20,105
Less: Fundraising	(7,443)
Less: Public Relations Expense	(20,105)
Non-allowable advertising	(971)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,490

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	646
Seminar Expense	3,185
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,831

**See instructions.

Facility Name & ID Number PRAIRIE VIEW HEALTHCARE # 0012922 Report Period Beginning: 12/01/01 Ending: 11/30/02

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? YES If YES, what is the capacity? 123

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,096 Line 4-2

(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 of Public Aid during this cost report period. $ 70,989
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(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? NO Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 50%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

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

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.