

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0052126 Facility Name: <u>Prairie Crossing Lvg & Rehab</u> Address: <u>409 W Comanche Ave</u> <u>Shabbona</u> <u>60550</u> Number City Zip Code County: <u>DeKalb</u> Telephone Number: <u>(815) 824-2194</u> Fax # <u>(815) 824-2188</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>12/1/12</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____	☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																																						
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Facility Name & ID Number Prairie Crossing Lvg & Rehab

0052126 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	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	<u>91</u>	Skilled (SNF)	<u>91</u>	<u>33,306</u>	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	<u>91</u>	TOTALS	<u>91</u>	<u>33,306</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>	<u>84</u>	<u>1,605</u>	<u>1,689</u>	8
9	SNF/PED					9
10	ICF	<u>15,091</u>	<u>3,823</u>	<u>3,051</u>	<u>21,965</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,091</u>	<u>3,907</u>	<u>4,656</u>	<u>23,654</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.02%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 12/01/12

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/01/12 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 91 and days of care provided 1,600

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	212,283	25,251	5,612	243,146		243,146		243,146			1
2	Food Purchase		187,023		187,023		187,023	(3,508)	183,515			2
3	Housekeeping	186,101	30,649		216,750		216,750	38	216,788			3
4	Laundry		11,888		11,888		11,888		11,888			4
5	Heat and Other Utilities			59,343	59,343		59,343	611	59,954			5
6	Maintenance	56,638	48,564	7,047	112,249		112,249	1,410	113,659			6
7	Other (specify):*											7
8	TOTAL General Services	455,022	303,375	72,002	830,399		830,399	(1,449)	828,950			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,269,750	65,132	16,149	1,351,031		1,351,031		1,351,031			10
10a	Therapy											10a
11	Activities	147,631	10,315		157,946		157,946		157,946			11
12	Social Services	34,455			34,455		34,455		34,455			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,451,836	75,447	22,149	1,549,432		1,549,432		1,549,432			16
	C. General Administration											
17	Administrative	118,073		181,200	299,273		299,273	(121,388)	177,885			17
18	Directors Fees											18
19	Professional Services			40,902	40,902		40,902	(17,010)	23,892			19
20	Dues, Fees, Subscriptions & Promotions			18,410	18,410		18,410	(2,810)	15,600			20
21	Clerical & General Office Expenses	87,760		43,926	131,686		131,686	42,194	173,880			21
22	Employee Benefits & Payroll Taxes			307,921	307,921		307,921	3,687	311,608			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,950	5,950		5,950	(482)	5,468			24
25	Other Admin. Staff Transportation			8,545	8,545		8,545	1,320	9,865			25
26	Insurance-Prop.Liab.Malpractice			66,770	66,770		66,770	114,451	181,221			26
27	Other (specify):* Management Allocation							5,481	5,481			27
28	TOTAL General Administration	205,833		673,624	879,457		879,457	25,443	904,900			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,112,691	378,822	767,775	3,259,288		3,259,288	23,994	3,283,282			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,925	12,925		12,925	119,019	131,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,778	5,778		5,778	188,091	193,869			32
33	Real Estate Taxes							33,943	33,943			33
34	Rent-Facility & Grounds			340,000	340,000		340,000	(340,000)				34
35	Rent-Equipment & Vehicles			8,779	8,779		8,779	10,231	19,010			35
36	Other (specify):*							46,029	46,029			36
37	TOTAL Ownership			367,482	367,482		367,482	57,313	424,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,475	209,204	245,679		245,679		245,679			39
40	Barber and Beauty Shops			52	52		52		52			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,383	182,383		182,383		182,383			42
43	Other (specify):* Non-Allowable Cos			35,827	35,827		35,827	(35,827)				43
44	TOTAL Special Cost Centers		36,475	427,466	463,941		463,941	(35,827)	428,114			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,112,691	415,297	1,562,723	4,090,711		4,090,711	45,480	4,136,191			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,279)	30		9
10	Interest and Other Investment Income	(21,499)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(398)	43		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	(150)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(736)	43		24
25	Fund Raising, Advertising and Promotional	(1,331)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,170)	43		28
29	Other-Attach Schedule See Page 5A	(121,259)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,822)		\$	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)	213,302		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 213,302		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 45,480		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Expense Med A	\$ (3,326)	43	1
2	X Ray Expense Med A	(1,761)	43	2
3	Managed Care Costs	(26,988)	43	3
4	Nonallowable Lobbying Expense	(3,081)	20	4
5	To disallow management fees	(67,641)	17	5
6	To disallow nonallowable legal	(1,019)	19	6
7	To disallow Marketing Consulting Fees	(16,580)	19	7
8	To disallow out of period seminar expense	(600)	24	8
9	Miscellaneous Income	(263)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(121,259)		49

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
See PG6-Supp		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

☐ 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	20	Licenses & Fees	\$	Prairie Crossing Property LLC	100%	\$ 250	\$ 250	1
2	V	26	Insurance		Prairie Crossing Property LLC	100%	159,524	159,524	2
3	V	30	Depreciation		Prairie Crossing Property LLC	100%	139,128	139,128	3
4	V	32	Interest	303	Prairie Crossing Property LLC	100%	146,664	146,361	4
5	V	32	Amortization		Prairie Crossing Property LLC	100%	63,229	63,229	5
6	V	33	Real Estate Taxes		Prairie Crossing Property LLC	100%	32,132	32,132	6
7	V	35	Rent Income	340,000	Prairie Crossing Property LLC	100%	9,659	(330,341)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 340,303			\$ 550,586	\$ * 210,283	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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)	
15	V	2	Food	\$	SW Financial Services Company		\$ 179	\$ 179	15
16	V	3	Housekeeping		SW Financial Services Company		38	38	16
17	V	5	Utilities		SW Financial Services Company		611	611	17
18	V	6	Maintenance		SW Financial Services Company		1,410	1,410	18
19	V	17	Administrative	61,200	SW Financial Services Company		7,453	(53,747)	19
20	V	19	Professional Services		SW Financial Services Company		589	589	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company		54	54	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company		42,457	42,457	22
23	V	24	Travel & Seminar		SW Financial Services Company		118	118	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company		1,320	1,320	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company		956	956	25
26	V	27	Other		SW Financial Services Company		5,481	5,481	26
27	V	30	Depreciation		SW Financial Services Company		1,170	1,170	27
28	V	33	Real Estate Taxes		SW Financial Services Company		1,811	1,811	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company		572	572	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 61,200			\$ 64,219	\$ * 3,019	39

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

Facility Name & ID Number

Prairie Crossing Lvg & Rehab

0052126

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Moshe Herman	72.5	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	4.5	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	4.5			SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	4.5			Services Co.		Management Comp	4
5	Robin Krystal	4	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove				5
6	David Zuckerman	10	Oregon Living & Rehabilitation, LLC	Oregon				6
7			Prairie Crossing Living & Rehab Center, LLC	Shabbona	Groves Community	Independence, MO	Hospice	7
8			Tower Hill Rehabilitation, LLC	South Elgin, IL	Hospice			8
9					Forest View Senior	Independence, MO	Independent	9
10			Beauvais Manor Healthcare and Rehab	St. Louis, MO	Residences		Living	10
11			Hillside Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Center		Care	12
13			Rosewood Health & Rehab	Independence, MO				13
14			Seasons Care Center	Kansas City, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Carriage Square	St. Joseph, MO	Program LLC			15
16			Linn Living & Rehabilitation Center	Linn, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20								20
21					FOM Property LLC	Franklin Grove	Real Estate	21
22								22
23					Oregon Property LLC	Oregon	Real Estate	23
24					Prairie Crossing	Shabbona	Real Estate	24
25					Property LLC			25
26								26
27					Tower Hill Property L	South Elgin	Real Estate	27
28								28
29								29
30								30

Facility Name & ID Number

Prairie Crossing Lvg & Rehab

0052126

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19					Linn Property LLC	Linn, MO	Real Estate	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Moshe Herman	Owner	Administrative	59.26	See Schedule 7A	13.33	33.33	Salary & Fees	\$ 52,359	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	14.81	See Schedule 7B	1	2.22	Salary	3,342	17, 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 55,701		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 Crossing Lvg & Rehab# 0052126

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

SW Financial Services Company

Street Address

7434 North Skokie Blvd

City / State / Zip Code

Skokie, IL 60077

Phone Number

(847) 982-2300

Fax Number

(847) 982-2304

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6				
1	2	Food	Bed Days Available	717,580	13	\$ 3,854	\$	33,306	\$ 179	1
2	3	Housekeeping	Bed Days Available	717,580	13	817		33,306	38	2
3	5	Utilities	Bed Days Available	717,580	13	13,161		33,306	611	3
4	6	Maintenance	Bed Days Available	717,580	13	30,368		33,306	1,410	4
5	19	Professional Services-Legal	Bed Days Available	717,580	13	46		33,306	2	5
6	19	Professional Services-Other	Bed Days Available	717,580	13	12,642		33,306	587	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	717,580	13	1,154		33,306	54	7
8	21	Clerical & General Office Expense	Bed Days Available	717,580	13	748,843	748,843	33,306	34,757	8
9	21	Clerical & General Office Expense	Bed Days Available	717,580	13	165,903		33,306	7,700	9
10	24	Travel & Seminar	Bed Days Available	717,580	13	2,553		33,306	118	10
11	25	Other Admin. Staff Transportion	Bed Days Available	717,580	13	28,429		33,306	1,320	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	717,580	13	20,601		33,306	956	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	717,580	13	118,085		33,306	5,481	13
14	33	Real Estate Taxes	Bed Days Available	717,580	13	39,025		33,306	1,811	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	717,580	13	12,328		33,306	572	15
16										16
17	17	Administrative	Avg. Hours Worked	45	13	185,000	185,000	1	4,111	17
18	17	Administrative	Avg. Hours Worked	45	13	150,387	150,387	1	3,342	18
19	30	Depreciation	Direct Cost	25,216					1,170	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,533,196	\$ 1,084,230		\$ 64,219	25

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	CapitalOne		X	Mortgage	\$ 29,692.33	1/1/2016	\$ 4,059,180	\$ 4,011,275	2/1/2051	0.0371	\$ 146,664	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Interest Only	3/15/13	200,000	300,000	9/15/17	0.0425	5,778	6
7												7
8												8
9	TOTAL Facility Related				\$29,692.33		\$ 4,259,180	\$ 4,311,275			\$ 152,442	9
	B. Non-Facility Related*											
10												10
11							Amortization of Loan Costs				63,229	11
12							Offset Interest Income				(21,802)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 41,427	14
15	TOTALS (line 9+line14)						\$ 4,259,180	\$ 4,311,275			\$ 193,869	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46029 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2015 report.	2015	\$	<u>33,196</u>	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.)		\$	<u>32,628</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(568)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>32,700</u>	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.			Alloc. Fr. Mgmt Co. 1,811	
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.		\$	<u>33,943</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	_____	8	
	2012	<u>33,689</u>	9	
	2013	<u>32,230</u>	10	
	2014	<u>31,807</u>	11	
	2015	<u>32,628</u>	12	
2016 Tax Accrual= 32,628 * 1.003=32,726				
Will use 32,700				

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2015 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

FACILITY NAME	<u>Prairie Crossing Living & Rehabilitation Center, LLC</u>	COUNTY	<u>DeKalb</u>
---------------	---	--------	---------------

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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

Page 10A

A. Square Feet: 19,645

B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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	Resident Care	122,902	1994	\$ 50,000	1
2					2
3	TOTALS	122,902		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	91		1994		\$ 2,643,587	\$	39	\$ 67,784	\$ 67,784	\$ 1,522,398
5										
6	Mgmt. Alloc		1995		19,342		39	553	553	11,967
7										
8										
	Improvement Type**									
9	Various		1989		2,650		20			2,650
10	Various		1990		65,810		20			65,810
11	Various		1991		20,536		20			20,536
12	Various		1992		5,466		10			5,466
13	Various		1993		13,848		20			13,848
14	Various		1994		39,334		20			39,334
15	Various		1995		13,479		20			13,479
16	Various		1996		11,533		20			11,533
17	Various		1997		18,996		20	950	950	18,811
18	Various		1998		141,664		20	7,021	7,021	132,616
19	Various		1999		2,415		20	121	121	2,137
20	Air Handler		2000		1,150		10			1,150
21	Air Handler		2000		1,870		10			1,870
22	Air Handler		2000		1,900		10			1,900
23	Driveway		2001		3,040		20	152	152	2,318
24	Nurses Call System		2001		2,745		10			2,745
25	Air Handler		2001		1,350		10			1,350
26	Security System		2001		1,507		10			1,507
27	Telephone System		2001		1,928		10			1,928
28	Heating and Cooling System		2002		1,078		20	54	54	786
29	Drapes		2003		1,528		10			1,528
30	Sidewalk Repair		2003		1,250		20	63	63	847
31	Wallpaper - North Dining Hall		2004		3,007		20	150	150	1,877
32	Air Handlers		2005		6,391		20	320	320	3,678
33	Windows, fascia and gutters & oversize downspouts		2005		60,785		20	3,039	3,039	34,950
34	Security control panel		2005		688		20	34	34	392
35	Patio & Fountain		2006		18,666		20	933	933	9,798
36	Fence		2006		2,008		20	100		1,051

*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 Crossing Lvg & Rehab

0052126

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	3 Glass Doors	2006	\$ 1,826	\$	10	\$ 89	\$ 89	\$ 1,826	37
38	Fire Alarm System	2006	5,392		20	270	270	2,834	38
39	Asphalt	2006	4,200		20	210	210	2,205	39
40	Landscaping	2006	99,698		20	4,985	4,985	52,342	40
41	Kitchen Air Conditioners	2007	5,193		20	260	260	2,469	41
42	Roof	2008	21,179		20	1,059	1,059	9,001	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036		20	802	802	6,817	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800		20	390	390	2,925	45
46									46
47	Repave Parking Lots	2010	6,798		20	340	340	2,210	47
48	Sealcoat Parking Lots	2010	2,610		20	131	131	851	48
49	Retaining Walls & Walkways	2010	16,190		20	796	796	5,157	49
50	Replanting Trees	2010	10,119		20	506	506	3,287	50
51	Remove and replace sidewalks	2011	17,386		20	869	869	3,912	51
52	Install cabinets for nurse's station	2011	19,000		20	950	950	5,225	52
53	Install Attic Heat Detector	2011	4,427		20	222	222	1,221	53
54	Plank Flooring	2011	46,744		20	2,338	2,338	12,859	54
55	Install fire dampers	2011	6,668		20	334	334	1,837	55
56	Install 4 ton Air Handler and 4 ton condensor	2011	15,694		20	784	784	4,312	56
57	Install 16 bathroom radiant exhaust fans	2011	7,000		20	350	350	1,925	57
58									58
59	Repair Plumbing	2013	4,115	150	40	103	(47)	360	59
60	New Water Line	2013	34,000	1,236	40	850	(386)	2,975	60
61	Sprinkler System	2013	136,367	4,959	40	3,409	(1,550)	11,932	61
62									62
63	75 Gallon Hot Water Heater	2014	4,502	164	40		(164)		63
64	Drain Tile Work	2014	5,000	238	40	42	(196)	125	64
65									65
66	Installed Steel Sleeve and New Concete Floor	2015	3,911	77	20	196	119	294	66
67	Removed and replace sidewalk	2015	19,230	13,304	20	962	(12,343)	1,443	67
68	Repair block wall, tuckpointing and stucco	2015	7,050		20	353	353	529	68
69	Laundry Chute Improvements - Sprinklers and vent for dryer	2015	2,930	58	20	147	89	220	69
70	TOTAL (lines 4 thru 69)		\$ 3,640,616	\$ 20,186		\$ 103,019	\$ 82,733	\$ 2,071,351	70

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab

0052126

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,640,616	\$ 20,186		\$ 103,019	\$ 82,833	\$ 2,071,351	1
2									2
3	Install dryer vents and gas pipes for dryer	2015	3,224	73	20	161	88	242	3
4	Replace electric hot water heater with gas water heater	2015	13,430	142	20	672	530	1,008	4
5	Install 24" catch basin, grate, and drain pipe	2015	2,975	1,507	20	149	(1,358)	223	5
6									6
7	Surveillance camera's - Entire Building	2016	14,590		5	1,459	1,459	1,459	7
8	Sidewalk from courtyard to parking lot	2016	3,685		15	123	123	123	8
9	Door Replacement - South Entrance	2016	21,000		15	700	700	700	9
10	Door Replacement - West Entrance	2016	21,000		15	700	700	700	10
11	Door Replacement - North Entrance	2016	21,000		15	700	700	700	11
12	Door Replacement in excess of amounts reported on lines 9-11	2016	4,229		15	141	141	141	12
13									13
14									14
15									15
16									16
17									17
18	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	2,165					2,165	18
19	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	360			7	7	359	19
20	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	418					418	20
21	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	357			18	18	335	21
22	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	992			50	50	847	22
23	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	2,052			103	103	1,180	23
24	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,162			58	58	552	24
25	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	2,427			120	120	910	25
26	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	1,295			65	65	227	26
27	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	1,306			65	65	163	27
28	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	268			18	18	27	28
29									29
30									30
31									31
32	To tie to financial statements			(12,868)			12,868		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,758,551	\$ 9,040		\$ 108,328	\$ 99,288	\$ 2,083,829	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 159,570	\$	\$ 19,197	\$ 19,197	5-10	\$ 113,429	71
72	Current Year Purchases	36,226	3,885	4,305	420	5-20	4,305	72
73	Fully Depreciated Assets	396,903			-		396,903	73
74	Allocated from Management Co.	6,357		114	114		5,451	74
75	TOTALS	\$ 599,056	\$ 3,885	\$ 23,616	\$ 19,731		\$ 520,088	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	Resident Care	1998 Oldsmobile	1998	\$ 21,506	\$	\$	\$ -	5	\$ 20,982
77	Resident Care	2001 Grand Jeep	2001	33,668			-	5	28,866
78	Resident Care	2004 Jeep	2004	25,644			-	5	25,644
79	Allocated from Management	2010 Infiniti	2010	3,436			-		3,436
80	TOTALS			\$ 84,254	\$ -	\$ -	\$ -		\$ 78,928

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$ 4,491,861	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 12,925	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 131,944	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 119,019	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 2,682,845	

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	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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.

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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 871 Description: Medical Supplies - \$871
(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	Administrative	2012 Jeep Cherokee	\$ 659	\$ 7,908	17
18	Allocated from Management Co. & RE			10,231	18
19					19
20					20
21	TOTAL		\$ 659.00	\$ 18,139	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.

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

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	1,082	\$ 77,872	\$	1,082	\$ 77,872	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		784	37,650		784	37,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,484	93,682		1,484	93,682	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				36,383		36,383	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					92		92	12
13	Other (specify): _____									13
14	TOTAL			\$	3,350	\$ 209,204	\$ 36,475	3,350	\$ 245,679	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.

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	\$ (64,569)	\$ (49,492)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,000))	1,486,326	1,486,326	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,900	40,921	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	263,473	664,303	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,719,130	\$ 2,142,058	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,662,929	14
15	Leasehold Improvements, at Historical Cost	241,496	1,095,622	15
16	Equipment, at Historical Cost	25,013	683,310	16
17	Accumulated Depreciation (book methods)	(62,370)	(2,682,845)	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 (spe See Schedule 17A		846,771	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 204,139	\$ 2,655,787	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,923,269	\$ 4,797,845	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,684	\$ 38,684	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,944	21,944	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	86,376	86,376	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,040	10,040	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32,700	32
33	Accrued Interest Payable		12,402	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	140,928	581,726	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 597,972	\$ 1,083,872	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,011,275	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	60,642	60,642	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 60,642	\$ 4,071,917	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 658,614	\$ 5,155,789	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,264,655	\$ (357,944)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,923,269	\$ 4,797,845	48

*(See instructions.)

Facility Name: Prairie Crossing Lvg & Rehab
IDPH License ID Number: 0052126
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	After	
	Operating	Consolidation
Due From State - Interest	38,242	38,242
Employee Payrooll Advance	5,293	5,293
Short Term Loan Exchange	23,435	23,435
Due to Public Aid	1,300	1,300
Due/From Property Option	195,203	195,203
Escrow - Replacement Reserve	-	117,587
Escrow - Insurance	-	22,247
Escrow - MIP	-	21,150
Escrow - Real Estate Taxes	-	14,426
Escrow - Non-Critical Repair	-	10,592
Escrow - Debt Service	-	116,983
Escrow - Pending Litigation	-	3
Mortgage Costs	-	97,842
Total - Line 9	263,473	664,303

XV. Balance Sheet
Line 22 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Goodwill - Prairie Crossing Living	-	910,000
Goodwill - Accum Amort Prairie Crossing Living	-	(63,229)
Total - Line 22	-	846,771

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Insurance Premiums Payable	26,797	26,797
Accrued Expenses	114,131	114,131
Due To/From Prairie Crossing Living	-	440,798
Total - Line 36	140,928	581,726

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,150,360	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,150,360	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	114,295	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)	\$ 114,295	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)	\$ 1,264,655	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Prairie Crossing Lvg & Rehab**# **0052126**Report Period Beginning: **01/01/2016**Ending: **12/31/2016****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense****1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,075,769	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,075,769	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,109	6
7	Oxygen	3,834	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 100,943	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		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		24
25	Interest and Other Investment Income***	21,499	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,499	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment	6,532	28
28a	Miscellaneous Income	263	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,795	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,205,006	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	830,399	31
32	Health Care	1,549,432	32
33	General Administration	879,457	33
	B. Capital Expense		
34	Ownership	367,482	34
	C. Ancillary Expense		
35	Special Cost Centers	281,558	35
36	Provider Participation Fee	182,383	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,090,711	40
41	Income before Income Taxes (line 30 minus line 40)**	114,295	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 114,295	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,583,939	44
45	Private Pay - Net Inpatient Revenue	698,438	45
46	Medicare - Net Inpatient Revenue	730,200	46
47	Other-(specify) Hospice	63,192	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,075,769	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **No^** 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.

^ - This entity is a cash basis taxpayer

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	361	361	\$ 12,135	\$ 33.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,121	13,605	371,558	27.31	3
4	Licensed Practical Nurses	9,901	10,363	249,290	24.06	4
5	CNAs & Orderlies	51,678	52,868	636,767	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,783	14,298	147,631	10.33	10
11	Social Service Workers	1,992	2,080	34,455	16.56	11
12	Dietician					12
13	Food Service Supervisor	2,013	2,148	29,467	13.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,698	19,660	182,816	9.30	15
16	Dishwashers					16
17	Maintenance Workers	4,447	4,556	56,638	12.43	17
18	Housekeepers	20,435	21,027	186,101	8.85	18
19	Laundry					19
20	Administrator	3,032	3,303	118,073	35.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,472	4,730	87,760	18.55	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					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,933	148,999	\$ 2,112,691 *	\$ 14.18	34

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	Monthly	\$ 5,612	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	1,532	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,424	10(3)	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)		\$ 19,568		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	234	8,193	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	234	\$ 8,193		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Prairie Crossing Lvg & Rehab

0052126

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Payton	Administrator	0	\$ 58,525
Carrie Wagner	Administrator	0	34,351
John Koehler	Administrator	0	25,197
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,073

B. Administrative - Other

Description	Amount
Moshe Herman / Momentum Healthcare, LLC	\$ 120,000
SW Financial Services Fees (Eliminated on Sch. V, Col. 7)	61,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 181,200

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLLP	Accounting	\$ 20,805
HK Payroll Services Co.	Accounting	239
Klein Consulting	Marketing Consultant	16,580
Personnel Planners, Inc.	Unemployment Consultant	1,650
Kitch Drutchas Wagner	Legal	418
Lisa Russell	Legal	400
Alan H. Cooper	Legal	810
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 40,902

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 68,042
Unemployment Compensation Insurance	30,857
FICA Taxes	159,515
Employee Health Insurance	38,494
Employee Meals	3,687
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	12,010
Holiday Expense	793
Uniforms	(1,790)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 311,608

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 235)	2,819
Patient Background Checks	
Illinois Council on Long Term Care	9,337
Miscellaneous Dues & Permits	775
Miscellaneous Inspections & Licenses	5,446
Allocated from Management Co. & RE	304
Less: Lobbying Expense	(3,081)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,600

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	5,350
Allocated from Management Co. & RE	118
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 5,468

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Prairie Crossing Lvg & Rehab
IDPH License ID Number: 0052126
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
From Page 21 Section C		40,902
Total (agree to Schedule V, line 19, column 3)		40,902
Allocated from Management Company Legal Fees		2
Allocated from Management Company Professional Services		587
Less: Non-Allowable Legal		(1,019)
Less: Non-Allowable Marketing Consultant		(16,580)
Total (agree to Schedule V, line 19, column 8)		23,892

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. Illinois Council on Long Term Care-\$9,337

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(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?

5-20 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 17,470

Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 182,383

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 benefit on Schedule V.

\$ 3,687

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

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?

N/A

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?

N/A

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?

No

Firm Name:

N/A

(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.

Yes

Attach invoices and a summary of services for all architect and appraisal fees

HFS 3745 (N-4-99)

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