FOR BHF USE

LL1

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0052126

Facility Name: Prairie Crossing Lvg & Rehab

Address: 409 W Comanche Ave (Number) Shabbona (City) 60550 (Zip Code)

County: DeKalb

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

HFS ID Number:

Date of Initial License for Current Owners: 12/1/12

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2013 to 12/31/2013 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,215	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	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		31	1,352	1,383	8
9	SNF/PED					9
10	ICF	14,307	5,505		19,812	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,307	5,536	1,352	21,195	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.81%

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

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

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

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

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 [X] Date 12/01/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 91 and days of care provided 1,352

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	211,079	11,603	4,824	227,506		227,506		227,506			1
2	Food Purchase		172,445		172,445		172,445	(4,635)	167,810			2
3	Housekeeping	188,375	42,535		230,910		230,910	58	230,968			3
4	Laundry	9,292	9,073		18,365		18,365		18,365			4
5	Heat and Other Utilities			65,390	65,390		65,390	764	66,154			5
6	Maintenance	22,849	43,804	6,751	73,404		73,404	2,742	76,146			6
7	Other (specify):*											7
8	**TOTAL General Services**	431,595	279,460	76,965	788,020		788,020	(1,071)	786,949			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,062,528	57,290	7,032	1,126,850		1,126,850		1,126,850			10
10a	Therapy											10a
11	Activities	101,852	5,137		106,989		106,989		106,989			11
12	Social Services	29,811			29,811		29,811		29,811			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,194,191	62,427	13,032	1,269,650		1,269,650		1,269,650			16
	C. General Administration											
17	Administrative	2,393		116,100	118,493		118,493	22,168	140,661			17
18	Directors Fees											18
19	Professional Services			25,797	25,797		25,797	(9,545)	16,252			19
20	Dues, Fees, Subscriptions & Promotions			14,787	14,787		14,787	(2,315)	12,472			20
21	Clerical & General Office Expenses	166,370		43,130	209,500		209,500	31,713	241,213			21
22	Employee Benefits & Payroll Taxes			246,215	246,215		246,215	4,506	250,721			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,600	5,600		5,600	(311)	5,289			24
25	Other Admin. Staff Transportation			6,555	6,555		6,555	1,084	7,639			25
26	Insurance-Prop.Liab.Malpractice			13,798	13,798		13,798	391	14,189			26
27	Other (specify):* Management Allocati							9,244	9,244			27
28	**TOTAL General Administration**	168,763		471,982	640,745		640,745	56,935	697,680			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,794,549	341,887	561,979	2,698,415		2,698,415	55,864	2,754,279			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 Crossing Lvg & Rehab #0052126 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,142	8,142		8,142	110,736	118,878			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,043	5,043		5,043	(2,122)	2,921			32
33	Real Estate Taxes			32,979	32,979		32,979	37,124	70,103			33
34	Rent-Facility & Grounds			188,922	188,922		188,922	(188,922)				34
35	Rent-Equipment & Vehicles			7,908	7,908		7,908	676	8,584			35
36	Other (specify):*											36
37	**TOTAL Ownership**			242,994	242,994		242,994	(42,508)	200,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,223	219,561	262,784		262,784		262,784			39
40	Barber and Beauty Shops			1,693	1,693		1,693		1,693			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,913	171,913		171,913		171,913			42
43	Other (specify):* **Non-Allowable Cos**			13,504	13,504		13,504	(13,504)				43
44	**TOTAL Special Cost Centers**		43,223	406,671	449,894		449,894	(13,504)	436,390			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,794,549	385,110	1,211,644	3,391,303		3,391,303	(148)	3,391,155			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 Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	(290)	2		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	11,691	30		9
10	Interest and Other Investment Income	(21,027)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(437)	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	(407)	43		24
25	Fund Raising, Advertising and Promotional	(2,085)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,596)	43		28
29	Other-Attach Schedule See Page 5A	85,178	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 69,027		$	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)	(69,175)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (69,175)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (148)		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

Prairie Crossing Lvg & Rehab

ID# 0052126

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (2,426)	43	1
2	X Ray Expense Med A	(264)	43	2
3	Managed Care Costs	(4,289)	43	3
4	To offset allocated wages	70,400	17	4
5	To adjust real estate taxes	(568)	33	5
6	To disallow related party rent	32,979	34	6
7	Nonallowable Lobbying Expense	(2,450)	20	7
8	To allocate management fees	216	17	8
9	Nonallowable Travel & Seminar	(537)	24	9
10	Offset Miscellaneous Income	(13)	21	10
11	Expense Improvements under $2500 to R/M	2,400	6	11
12	To disallow nonallowable legal	(10,270)	19	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**	85,178		49

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Shabbona Building Associates LLC	100.00%	$ 96,990	$ 96,990	1
2	V	32	Interest	39,307	Shabbona Building Associates LLC	100.00%	55,291	15,984	2
3	V	32	Amortization-Mortgage Costs		Shabbona Building Associates LLC	100.00%	2,921	2,921	3
4	V	33	Real Estate Taxes		Shabbona Building Associates LLC	100.00%	35,979	35,979	4
5	V	34	Rent	221,901	Shabbona Building Associates LLC	100.00%		(221,901)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 261,208			$ 191,181	$ * (70,027)	14

*** 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: 1/1/2013 Ending: 12/31/2013

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Financial Services Company	100.00%	$ 161	$ 161	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	58	58	16
17	V	5	Utilities		SW Financial Services Company	100.00%	764	764	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	342	342	18
19	V	17	Administrative	56,100	SW Financial Services Company	100.00%	7,652	(48,448)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	725	725	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	135	135	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	31,726	31,726	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	226	226	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,084	1,084	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	391	391	25
26	V	27	Other		SW Financial Services Company	100.00%	9,244	9,244	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	2,055	2,055	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	1,713	1,713	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	676	676	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			$ 56,100			$ 56,952	$ * 852	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: 1/1/2013 Ending: 12/31/2013

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	72.50%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	4.50%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	4.50%	Green Acres Healthcare & Rehab Center LLC	Amboy	SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	4.50%			Services Co.		Management Comp.	4
5	Robin Krystal	4.00%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove				5
6	David Zuckerman	10.00%	Oregon Living & Rehabilitation, LLC	Oregon				6
7			Prairie Crossing Living & Rehab Center, LLC	Shabbona				7
8								8
9								9
10			Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11			Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13			Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14			Seasons Care Center	Kansas City, MO	Residences		Living	14
15					White Oak Living	Independence, MO	Residential	15
16					Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LL	Caseyville	Real Estate	22
23					Green Acres Property	Amboy	Real Estate	23
24								24
25								25
26					FOM Property LLC	Franklin Grove	Real Estate	26
27					Oregon Property LLC	Oregon	Real Estate	27
28					Shabbona Building	Shabbona	Real Estate	28
29					Associates LLC			29
30								30

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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								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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	Moshe Herman	Owner	Administrative	50.00	See Schedule 7A	13.33	33.33	Salary & Fees	$ 60,216	17,3 & 17,7	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	$ 60,216		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: 1/1/2013 Ending: 2/31/2013

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: 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 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	2	Food	Bed Days Available	633,958	12	$ 3,076	$	33,215	$ 161	1
2	3	Housekeeping	Bed Days Available	633,958	12	1,102		33,215	58	2
3	5	Utilities	Bed Days Available	633,958	12	14,583		33,215	764	3
4	6	Maintenance	Bed Days Available	633,958	12	6,537		33,215	342	4
5	19	Professional Services-Legal	Bed Days Available	633,958	12	2,469		33,215	129	5
6	19	Professional Services-Other	Bed Days Available	633,958	12	11,379		33,215	596	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	633,958	12	2,583		33,215	135	7
8	21	Clerical & General Office Expens	Bed Days Available	633,958	12	522,868	522,868	33,215	27,395	8
9	21	Clerical & General Office Expens	Bed Days Available	633,958	12	82,658		33,215	4,331	9
10	24	Travel & Seminar	Bed Days Available	633,958	12	4,312		33,215	226	10
11	25	Other Admin. Staff Transportion	Bed Days Available	633,958	12	20,693		33,215	1,084	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	633,958	12	7,467		33,215	391	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	633,958	12	176,429		33,215	9,244	13
14	33	Real Estate Taxes	Bed Days Available	633,958	12	32,704		33,215	1,713	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	633,958	12	12,906		33,215	676	15
16										16
17	17	Administrative	Avg. Hours Worked	45	12	215,400	215,400	1	4,787	17
18	17	Administrative	Avg. Hours Worked	45	12	128,945	128,945	1	2,865	18
19	30	Depreciation	Direct Cost	39,214					2,055	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,246,112	$ 867,213		$ 56,952	25

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Interest Only	12/1/13	125,000	125,000	12/1/14	0.0425	5,043	6
7	Meadows of Franklin Grove Ap	X		Working Capital		11/1/12	150,000		11/1/13	0.0400	6,029	7
8												8
9	TOTAL Facility Related						$ 275,000	$ 125,000			$ 11,072	9
	B. Non-Facility Related*											
10									Amortization of loan costs		2,921	10
11									Interest Income Offset		(11,072)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,151)	14
15	TOTALS (line 9+line14)						$ 275,000	$ 125,000			$ 2,921	15

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

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

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2012**	$ 33,689	2
3. Under or (over) accrual (line 2 minus line 1).		$ 33,689	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,700	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
	Allocated from Management Co.	1,714	
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.		$ 70,103	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012	33,689	12

2013 Tax Accrual= 33,689 *1.03 = 34,700

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Crossing Lvg & Rehab COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0052126

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long Term Care Property	$ 33,689.08	$ 33,689.08
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 35,417.26	$ 1,714.40
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,106.34	$ 35,403.48

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,200 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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. [ ] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1994	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$	39	$ 67,784	$ 67,784	$ 1,319,045	4
5											5
6			Allocated from Management C		20,940		40	598	598	11,161	6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650		20			2,650	9
10	Various			1990	65,810		20			65,810	10
11	Various			1991	20,536		20			20,536	11
12	Various			1992	5,466		10			4,191	12
13	Various			1993	13,848		20	572	572	13,848	13
14	Various			1994	39,334		20	1,967	1,967	38,910	14
15	Various			1995	13,479		20	655	655	13,479	15
16	Various			1996	11,533		20	577	577	10,964	16
17	Various			1997	18,996		20	950	950	15,961	17
18	Various			1998	141,664		20	7,021	7,021	111,553	18
19	Various			1999	2,415		20	121	121	1,774	19
20	Air Handler			2000	1,150		10			1,150	20
21	Air Handler			2000	1,870		10			1,870	21
22	Air Handler			2000	1,900		10			1,900	22
23	Driveway			2001	3,040		20	152	152	1,862	23
24	Nurses Call System			2001	2,745		10			2,745	24
25	Air Handler			2001	1,350		10			1,350	25
26	Security System			2001	1,507		10			1,507	26
27	Telephone System			2001	1,928		10			1,928	27
28	Heating and Cooling System			2002	1,078		20	54	54	624	28
29	Drapes			2003	1,528		10	37	37	1,528	29
30	Sidewalk Repair			2003	1,250		20	63	63	658	30
31	Wallpaper - North Dining Hall			2004	3,007		20	150	150	1,427	31
32	Air Handlers			2005	6,391		20	320	320	2,718	32
33	Windows, fascia and gutters & oversize downspouts			2005	60,785		20	3,039	3,039	25,833	33
34	Security control panel			2005	688		20	34	34	290	34
35	Patio & Fountain			2006	18,666		20	933	933	6,999	35
36	Fence			2006	2,008		20	100	100	751	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 Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	3 Glass Doors	2006	$ 1,826	$	10	$ 183	$ 183	$ 1,371	37
38	Fire Alarm System	2006	5,392		20	270	270	2,024	38
39	Asphalt	2006	4,200		20	210	210	1,575	39
40	Landscaping	2006	99,698		20	4,985	4,985	37,387	40
41	Kitchen Air Conditioners	2007	5,193		20	260	260	1,689	41
42	Roof	2008	21,179		20	1,059	1,059	5,824	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036		20	802	802	4,411	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800		20	390	390	1,755	45
46									46
47	Repave Parking Lots	2010	6,798		20	340	340	1,190	47
48	Sealcoat Parking Lots	2010	2,610		20	131	131	458	48
49	Retaining Walls & Walkways	2010	16,190		20	796	796	2,769	49
50	Replanting Trees	2010	10,119		20	506	506	1,769	50
51	Remove and replace sidewalks	2011	17,386		20	869	869	1,304	51
52	Install cabinets for nurse's station	2011	19,000		20	950	950	2,375	52
53	Install Attic Heat Detector	2011	4,427		20	222	222	555	53
54	Plank Flooring	2011	46,744		20	2,338	2,338	5,845	54
55	Install fire dampers	2011	6,668		20	334	334	835	55
56	Install 4 ton Air Handler and 4 ton condensor	2011	15,694		20	784	784	1,960	56
57	Install 16 bathroom radiant exhaust fans	2011	7,000		20	350	350	875	57
58									58
59	Repair Plumbing	2013	4,115	119	40	51	(68)	51	59
60	New Water Line	2013	34,000	464	40	425	(39)	425	60
61	Sprinkler System	2013	136,367	620	40	1,705	1,085	1,705	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,599,591	$ 1,203		$ 103,088	$ 101,885	$ 1,763,174	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: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,599,591	$ 1,203		$ 103,088	$ 101,885	$ 1,763,174	1
2	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	2,344			115	115	2,344	2
3	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	390			20	20	343	3
4	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	452			23	23	429	4
5	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	387			19	19	305	5
6	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,074			54	54	756	6
7	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	2,222			111	111	944	7
8	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,258			63	63	409	8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	2,626			131	131	591	9
10	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	1,402			35	35	35	10
11									11
12									12
13									13
14	Adjust to financial statements			54			(54)		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	TOTAL (lines 1 thru 33)		$ 3,611,746	$ 1,257		$ 103,659	$ 102,402	$ 1,769,329	34

**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: 1/1/2013 Ending: 12/31/2013

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	$ 137,604	$	$ 13,760	$ 13,760	5-10	$ 60,725	71
72	Current Year Purchases	11,475	6,885	574	(6,311)	10	574	72
73	Fully Depreciated Assets	396,903					396,903	73
74	Allocated from Management Co.	6,755		141	141		5,523	74
75	TOTALS	$ 552,737	$ 6,885	$ 14,475	$ 7,590		$ 463,725	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	76
77	Resident Care	2001 Grand Jeep	2001	33,668				5	28,866	77
78	Resident Care	2004 Jeep	2004	25,644				5	25,644	78
79	Allocated from Management	2010 Infiniti	2010	3,720		744	744		2,604	79
80	TOTALS			$ 84,538	$	$ 744	$ 744		$ 78,096	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,299,021	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,142	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,878	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 110,736	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,311,150	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (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	$ 659.00	$ 7,908	17
18	Allocated from Management Co.			676	18
19					19
20					20
21	TOTAL		$ 659.00	$ 8,584	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 Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

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

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	1,265	$ 91,102	$	1,265	$ 91,102	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		203	14,636		203	14,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,581	113,823		1,581	113,823	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				42,329		42,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					894		894	12
13	Other (specify):									13
14	TOTAL			$	3,049	$ 219,561	$ 43,223	3,049	$ 262,784	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.

STATE OF ILLINOIS

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	8,663	8,663	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,332)	820,300	820,300	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,020	3,020	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		2,469,860	8
9	Other(specify): See Schedule 17A	76,508	76,508	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 909,491	$ 3,379,351	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		2,664,527	14
15	Leasehold Improvements, at Historical Cost	176,882	947,219	15
16	Equipment, at Historical Cost	11,475	637,275	16
17	Accumulated Depreciation (book methods)	(8,142)	(2,311,150)	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		30,601	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 180,215	$ 2,018,472	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,089,706	$ 5,397,823	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,068	$ 126,068	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,821	23,821	28
29	Short-Term Notes Payable	125,000	125,000	29
30	Accrued Salaries Payable	48,846	48,846	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,107	10,107	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,700	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	267,485	539,485	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 601,327	$ 908,027	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	Prior Owner Balance	2,997	2,997	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,997	$ 2,997	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 604,324	$ 911,024	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 485,382	$ 4,486,799	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,089,706	$ 5,397,823	48

***(See instructions.)**

Prairie Crossing Living & Rehabiliation Center, LLC
0052126
12/31/2013

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due from State - Interest	736	736
Reimbursement Due	6,198	6,198
Deposit Option	72,000	72,000
Due /From Property Option	(2,426)	(2,426)
Total Line 9-Other Current Assets (Specify)	76,508	76,508

Other Long-Term Assets (Specify):	Operating	After Consolidation
Loan Costs	-	87,616
Accum Amort - Loan Costs	-	(57,015)
Total Line 22-Other Long Term Assets (Specify)	-	30,601

Other Current Liabilities (Specify)		
Short Term Loan Exchange	844	844
Insurance Premiums Payable	3,342	3,342
Accrued Expenses	263,299	263,299
Options Deposit	-	72,000
Due T/F Woodglen	-	200,000
Total Line 36-Other Current Liabilities (Specify)	267,485	539,485

Facility Name & ID Number Prairie Crossing Lvg & Rehab **#** 0052126 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 247,581	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 247,581	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	237,801	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)**	$ 237,801	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)**	$ 485,382	24	*

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

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,432,264	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,432,264	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	183,992	6
7	Oxygen	3,279	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 187,271	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	1,669	13
14	Non-Patient Meals	290	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)**	$ 1,959	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,838	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,838	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustments	5,772	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,772	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,629,104	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	788,020	31
32	Health Care	1,269,650	32
33	General Administration	640,745	33
	B. Capital Expense		
34	Ownership	242,994	34
	C. Ancillary Expense		
35	Special Cost Centers	277,981	35
36	Provider Participation Fee	171,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,391,303	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,801	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,801	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,338,474	44
45	Private Pay - Net Inpatient Revenue	495,051	45
46	Medicare - Net Inpatient Revenue	596,219	46
47	Other-(specify) Hospice	2,520	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,432,264	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.

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,748	1,748	$ 49,869	$ 28.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,561	7,985	198,399	24.85	3
4	Licensed Practical Nurses	11,726	12,014	278,444	23.18	4
5	CNAs & Orderlies	49,923	52,691	535,816	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,212	10,681	101,852	9.54	10
11	Social Service Workers	2,080	2,080	29,811	14.33	11
12	Dietician					12
13	Food Service Supervisor	544	624	9,763	15.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,129	21,913	201,316	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,475	1,543	22,849	14.81	17
18	Housekeepers	19,977	20,927	188,375	9.00	18
19	Laundry	1,089	1,126	9,292	8.25	19
20	Administrator	80	128	2,393	18.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,953	9,455	166,370	17.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,497	142,915	$ 1,794,549 *	$ 12.56	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,824	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,771	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)		$ 15,595		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	47	2,261	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	47	$ 2,261		53

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jenny Donahue	Administrator	0	$ 2,393
See Schedule 21 A			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 2,393

B. Administrative - Other

Description	Amount
Moshe Herman / Momentum Healthcare, LLC	$ 60,000
SW Financial Services Fees (Eliminated on Sch. V, Col. 7)	56,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 116,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Law Office of Stephen N. Sher	Legal	$ 14,064
Dan Parsons Attorney at Law	Legal	1,560
McGladrey, LLP	Accounting	9,533
Personnel Planners, Inc.	Unemployment Consultant	640
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,797

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,785
Unemployment Compensation Insurance	44,670
FICA Taxes	139,423
Employee Health Insurance	5,140
Employee Meals	4,506
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	4,657
Holiday Expense	1,313
Uniforms	(773)
TOTAL (agree to Schedule V, line 22, col.8)	$ 250,721

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 31)	376
Patient Background Checks	
Illinois Council on Long Term Care	9,181
Miscellaneous Dues & Permits	330
Miscellaneous Inspections & Licenses	2,910
Allocated from Management Co.	135
Less: Public Relations Expense	( )
Lobbying Expense	(2,450)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,472

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,600
Nonallowable Seminar	(537)
Allocated from Management Co.	226
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,289

* Attach copy of IMRF notifications

**See instructions.

Prairie Crossing Living & Rehabiliation Center, LLC
0052126
12/31/2013

XIX. Support Schedule
A. Administrative Salaries

Total (Agree to Schedule V, Line 17, Column 1)			2,393
Name	***Function***	***Ownership***	***Amount***
Dana Payton	Administrator	100%	70,400
Allocated from Management Company			7,652
Total (Agree to Schedule V, Line 17 Final Administrator Salary)			80,445

Prairie Crossing Living & Rehabiliation Center, LLC
0052126
12/31/2013

XIX. Support Schedule
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	25,797
Allocated from Management Company-Accounting	596
Allocated from Management Company-Legal	129
Total Allocated from Management Company	829
Nonallowable Legal	(10,270)
Total (Agree to Schedule V, Line 19, Column8)	16,252

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3											N/A		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie Crossing Lvg & Rehab # 0052126 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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-$9,181**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,913** 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. $ **171,913**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,506** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **290**

(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 out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.