FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

I. Facility ID Number: 1000060

Facility Name: Prairie Crossing

Address: 407 W Comanche Ave (Number) | Shabbona (City) | 60550 (Zip Code)

County: DeKalb

Telephone Number: (815) 824-8480 **Fax #** (815) 824-2412

Federal Employer ID Number:

Date Current Owners were Certified: 3/30/06

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 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

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

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

Facility Name Prairie Crossing Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units N/A

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	29	Single Unit Apartment	29	10,614	1
2	7	Double Unit Apartment	7	2,562	2
3		Other			3
4	36	TOTALS	36	13,176	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,054	3,850	200	10,104	5
6	Double Unit	1,464	1,464		2,928	6
7	Other					7
8	TOTALS	7,518	5,314	200	13,032	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.91%

D. Indicate the number of paid bed-hold days the SLF had during this year 47 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** N/A **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?
YES [X] NO [ ]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

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

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain. N/A

Facility Name: Prairie Crossing **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	108,559	78,167	1,658	188,384		188,384	1
2	Housekeeping, Laundry and Maintenance	33,393	22,094	2,657	58,144	2,497	60,641	2
3	Heat and Other Utilities			40,764	40,764		40,764	3
4	Other (specify):							4
5	**TOTAL General Services**	141,952	100,261	45,079	287,292	2,497	289,789	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	252,193	840	1,000	254,033		254,033	6
7	Activities and Social Services	23,550	10,217		33,767		33,767	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	275,743	11,057	1,000	287,800		287,800	9
	C. General Administration							
10	Administrative and Clerical	97,320		26,322	123,642	(321)	123,321	10
11	Marketing Materials, Promotions and Advertising			8,773	8,773	(8,773)		11
12	Employee Benefits and Payroll Taxes			84,597	84,597		84,597	12
13	Insurance-Property, Liability and Malpractice			5,847	5,847	105,181	111,028	13
14	Other (specify):							14
15	**TOTAL General Administration**	97,320		125,539	222,859	96,087	318,946	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	515,015	111,318	171,618	797,951	98,584	896,535	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			3,508	3,508	96,967	100,475	17
18	Interest			1,548	1,548	137,714	139,262	18
19	Real Estate Taxes					28,805	28,805	19
20	Rent -- Facility and Grounds			198,908	198,908	(174,574)	24,334	20
21	Rent -- Equipment			56	56		56	21
22	Other (specify):							22
23	**TOTAL Ownership**			204,020	204,020	88,912	292,932	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	515,015	111,318	375,638	1,001,971	187,496	1,189,467	24

Facility Name: Prairie Crossing **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	$ 26.65	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.91	11.95	3
4	Activity Director & Assistants	1.00	11.32	4
5	Social Service Workers			5
6	Head Cook	0.12	13.15	6
7	Cook Helpers/Assistants	5.74	8.82	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1.63	9.86	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	2.00	23.39	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19.40	$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	See Schedule 4A			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	$	1
2			2
		Total $	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name 1	City 2
See Schedule 4A	

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
See Schedule 4A		

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [ ] NO [X]

Name of related entity: _____ **If yes, what is the value of those services? $** _____

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES [X] NO [ ]

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Prairie Crossing Assisted Living, LLC
12/31/2016
Schedule 4A

VI.A
Owners:

Name	Ownership Interest	Avg. Hours per Work Week	Compensation
Moshe Herman	72.50%	10	N/A
Stuart Milstein	4.50%	N/A	N/A
Ari Milstein	4.50%	N/A	N/A
Elana Minkove	4.50%	N/A	N/A
Robin Krystal	4.00%	N/A	N/A
David Zuckerman	10.00%	N/A	N/A
TOTAL	**100.00%**		

VII. A

Related Organizations: Related SLF's & Health Care Businesses	City
In State	
Cahokia Nursing and Rehab, Inc.	Cahokia
Caseyville Nursing and Rehab, Inc.	Caseyville
Franklin Grove Living & Rehabilitation, LLC	Franklin Grove
Oregon Living & Rehabilitation, LLC	Oregon
Prairie Crossing Living & Rehab Center, LLC	Shabbona
Tower Hill Rehab LLC	South Elgin
Out of State	
Beauvais Manor Healthcare and Rehab	St. Louis, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO
Rosewood Health & Rehab	Independence, MO
Seasons Care Center	Kansas City, MO
Carriage Square Living & Rehab	St. Joseph, MO
Linn Living & Rehabilitation Center	Linn, MO

Other Related Business Entities

Name	City	Type of Business
SW Financial Services Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply	Skokie	Medical Supplies
Groves Community Hospice	Independence, MO	Hospice
Forest View Senior Residences	Independence, MO	Independent Living
White Oak Living Center	Independence, MO	Residential Care
Seasons Day Services Program, LLC	Kansas City, MO	Adult Day Care
Cahokia Building LLC	Cahokia	Real Estate
Caseyville Property LLC	Caseyville	Real Estate
Green Acres Property	Amboy	Real Estate
FOM Property LLC	Franklin Grove	Real Estate
Oregon Property LLC	Oregon	Real Estate
Prairie Crossing Property LLC	Shabbona	Real Estate
Tower Hill Property, LLC	South Elgin	Real Estate
Beauvais Manor Property, LLC	St. Louis, MO	Real Estate
Hillside Manor Real Estate & Development	St. Louis, MO	Real Estate
Rancho Manor Property, LLC	Florissant, MO	Real Estate
The Groves & Rest Haven Property, LLC	Independence, MO	Real Estate
Seasons Property, LLC	Kansas City, MO	Real Estate
Carriage Square Property LLC	St. Joseph, MO	Real Estate
Linn Property LLC	Linn, MO	Real Estate

Facility Name: Prairie Crossing Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 33,632 Year land was acquired 2000

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	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	
1	36		2006	2006	$ 2,605,419	$	28	$ 95,156	$ 95,156	$ 923,170	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Laundry Room			2007	12,716		27.5	462	462	4,486	6
7	Carpet			2007	4,998		27.5	182	182	1,661	7
8	Check valve			2008	5,435		27.5	198	198	1,609	8
9	Fence			2008	2,434		15	162	162	1,085	9
10	Elevator Motor			2009	8,133		27.5	296	296	2,208	10
11	Carpet			2009	2,798		27.5	102	102	803	11
12	Build Office Space in Lower Level			2014	12,380	94	27.5	94		282	12
13	Install handrails in cooridors			2015	11,787	450	27.5	214	(236)	428	13
14	Replace Flooring in Dining Room			2015	4,654	54	5	465	411	930	14
15	Replace Governor in Elevator			2016	12,457	132	27.5	226	94	226	15
16											16
17	TOTAL (lines 1 thru 16)				$ 2,683,211	$ 730		$ 97,557	$ 96,827	$ 936,888	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	$ 122,002	$	$ 2,918	2,918	5	$ 110,330	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 122,002	$	$ 2,918	2,918		$ 110,330	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21	N/A	$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: Prairie Crossing **Report Period Beginning:** 01/01/2016 **Ending:** 2/31/2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

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?** ☐ YES ☐ NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building	N/A		/ /	$ N/A			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				$			7

8. **Is movable equipment rental included in building rental?** ☐ YES ☐ NO

9. **Rental amount for movable equipment $** 56

10. **If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.**

X. INTEREST EXPENSE

	1 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related Long-Term										
1	Capital One		X	Mortgage	1/1/16	$ 2,706,120	$ 2,674,184	2/1/51	0.0371	$ 96,702	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6	Security Deposit Interest				/ /			/ /		1,548	6
7	TOTAL Facility Related					$ 2,706,120	$ 2,674,184			$ 98,250	7
	B. Non-Facility Related										
8					/ /	Security Deposit Interest Offset		/ /		(696)	8
9					/ /	Amortization of Loan Costs		/ /		41,708	9
10	TOTALS (lines 7, 8 and 9)					$ 2,706,120	$ 2,674,184			$ 139,262	10

* If there is an option to buy the building, please provide complete details on an attached schedule.
** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Prairie Crossing **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 600	$ 600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	316,592	316,592	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,503	14,184	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		201,992	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 326,695	$ 533,368	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		33,632	13
14	Buildings, at Historical Cost		2,605,419	14
15	Leasehold Improvements, at Historical Cost	41,278	77,792	15
16	Equipment, at Historical Cost	10,926	122,002	16
17	Accumulated Depreciation (book methods)	(17,189)	(1,047,218)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See Sch 7A	467,959	1,026,251	22
23	Other(specify): Mortgage Costs		65,228	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 502,974	$ 2,883,106	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 829,669	$ 3,416,474	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,153	$ 3,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	23,524	23,524	29
30	Accrued Salaries Payable	20,584	20,584	30
31	Accrued Taxes Payable	43,520	68,780	31
32	Accrued Interest Payable		8,268	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Schedule 7A	13,596	258,340	35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 114,377	$ 382,598	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		2,674,184	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$	$ 2,674,184	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 114,377	$ 3,056,782	45
46	**TOTAL EQUITY**	$ 715,292	$ 359,692	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 829,669	$ 3,416,474	47

***(See instructions.)**

Prairie Crossing
12/31/2016

Schedule 7A

XI. Balance Sheet

B. Long-Term Assets

Line 22: Other long-term assets

Description	Operating	After Consolidation
Due/From SLF Building Partn	467,959	467,959
Goodwill	-	600,000
Accum. Amortization - PCA	-	(41,708)
	467,959	1,026,251

XI. Balance Sheet

C. Current Liabilities

Line 35: Other current Liabilities

Description	Operating	After Consolidation
Insurace Premiums Payable	5,073	5,073
FICA Withholding	1,442	1,442
Accrued Expenses	7,450	7,450
Due to Public Aid	(369)	(369)
Due TO/From PCA	-	244,744
	13,596	258,340

Facility Name: Prairie Crossing **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,316,160	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,316,160	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	496	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 496	14
	D. Other Revenue (specify):		
15			15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,316,656	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	287,292	19
20	Health Care/ Personal Care	287,800	20
21	General Administration	222,859	21
	B. Capital Expense		
22	Ownership	204,020	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 1,001,971	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 314,685	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 314,685	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 760,172	32
33	Private Pay - Net Inpatient Revenue	555,988	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,316,160	37