

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2018  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2018)**

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.

<p><b>I. Facility ID Number:</b> <u>1000060</u></p> <p><b>Facility Name:</b> <u>Prairie Crossing</u></p> <hr/> <p><b>Address:</b> <u>407 W Comanche Ave</u> <u>Shabbona</u> <u>60550</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>DeKalb</u></p> <p><b>Telephone Number:</b> <u>( 815 ) 824-8480</u> <b>Fax #</b> <u>(815) 824-2412</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>3/30/06</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</u> to <u>12/31/2018</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:20%; vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 6017</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(847 ) 517-7070</u> <b>Fax</b> <u>(847) 517-7067</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 <span style="float:right">Phone # (217) 782-1630</span></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 6017</u>		(Telephone) <u>(847 ) 517-7070</u> <b>Fax</b> <u>(847) 517-7067</u>	
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<p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Amanda Springborn</u> <b>Telephone Number:</b> <u>( 314) 925-3838</u></p> <p><b>Email Address:</b> _____</p>																																										

Facility Name Prairie Crossing

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

**III. STATISTICAL DATA**

**A. Certified units; enter number of units and unit days**

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	29	Single Unit Apartment	29	10,585	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	36	TOTALS	36	13,140	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	6,750	2,472	727	9,949	5
6	Double Unit		2,486		2,486	6
7	Other					7
8	TOTALS	6,750	4,958	727	12,435	8

**C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)** 94.63%

**D. Indicate the number of paid bed-hold days the SLF had during this year**

54 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  NO  Note : Non-allowable costs have been eliminated in Schedule IV, Column 5.

**F. Does the BALANCE SHEET reflect any non-SLF assets?**

YES  NO

**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  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

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

\* 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:

01/01/2018

Ending: 12/31/2018

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	112,671	85,389	1,322	199,382		199,382	1
2	Housekeeping, Laundry and Maintenance	35,061	24,084	4,641	63,786		63,786	2
3	Heat and Other Utilities			43,025	43,025		43,025	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	147,732	109,473	48,988	306,193		306,193	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	259,044	2,631	1,000	262,675		262,675	6
7	Activities and Social Services	25,212	12,525		37,737		37,737	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	284,256	15,156	1,000	300,412		300,412	9
<b>C. General Administration</b>								
10	Administrative and Clerical	111,588		95,308	206,896	(8,635)	198,261	10
11	Marketing Materials, Promotions and Advertising			4,150	4,150	(4,150)		11
12	Employee Benefits and Payroll Taxes			73,604	73,604		73,604	12
13	Insurance-Property, Liability and Malpractice					35,100	35,100	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	111,588		173,062	284,650	22,315	306,965	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	543,576	124,629	223,050	891,255	22,315	913,570	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			16,470	16,470	91,656	108,126	17
18	Interest			34	34	18,654	18,688	18
19	Real Estate Taxes					26,618	26,618	19
20	Rent -- Facility and Grounds			216,000	216,000	(216,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			232,504	232,504	(79,072)	153,432	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	543,576	124,629	455,554	1,123,759	(56,757)	1,067,002	24

Facility Name: **Prairie Crossing**

Report Period Beginning: **01/01/2018**

Ending:

**12/31/2018**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	\$ 28.73	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.98	12.01	3
4	Activity Director & Assistants	1.00	12.12	4
5	Social Service Workers			5
6	Head Cook	1.30	9.74	6
7	Cook Helpers/Assistants	3.87	10.69	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1.59	10.58	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	1.75	30.66	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18.49</b>	<b>\$</b>	<b>17</b>

**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	
				<b>Total</b>	<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee		
1	N/A	\$	1	
2			2	
		<b>Total</b>	<b>\$</b>	<b>3</b>

**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

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  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**  
**12/31/2018**  
**Schedule 4A**

VI.A

**Owners:**

<u>Name</u>	<u>Ownership Interest</u>	<u>Avg. Hours per Work Week</u>	<u>Compensation</u>
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
<b>TOTAL</b>	<b>100.00%</b>		

VII. A

**Related Organizations: Related SLF's & Health Care Businesses**

<u>In State</u>	<u>City</u>
Cahokia Nursing and Rehab, Inc.	Cahokia
Caseyville Nursing and Rehab, Inc.	Caseyville
Franklin Grove Living & Rehabilitation, LLC	Franklin Grove
Maple Crossing at Amboy, LLC	Amboy
Oregon Living & Rehabilitation, LLC	Oregon
Prairie Crossing Living & Rehab Center, LLC	Shabbona
Tower Hill Rehab LLC	South Elgin
<u>Out of State</u>	
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

**Other Related Business Entities**

<u>Name</u>	<u>City</u>	<u>Type of Business</u>
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

Facility Name: **Prairie Crossing**

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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	\$ 1,018,326	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Laundry Room		2007	12,716		27.5	462	462	5,410	6
7		Carpet		2007	4,998		27.5	182	182	2,025	7
8		Check valve		2008	5,435		27.5	198	198	2,005	8
9		Fence		2008	2,434		15	162	162	1,409	9
10		Elevator Motor		2009	8,133		27.5	296	296	2,800	10
11		Carpet		2009	2,798		27.5	102	102	1,007	11
12		Build Office Space in Lower Level		2014	12,380	450	27.5	450		1,444	12
13		Install handrails in cooridors		2015	11,787	429	27.5	429		1,072	13
14		Replace Flooring in Dining Room		2015	4,654		5	931	931	3,258	14
15		Replace Governor in Elevator		2016	12,457	453	27.5	453		1,132	15
16		See 5A			18,537			1,470	1,470	1,470	16
17		<b>TOTAL (lines 1 thru 16)</b>			\$ 2,701,748	\$ 1,332		\$ 100,291	\$ 98,959	\$ 1,041,358	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	\$ 149,074	\$	\$ 7,835	7,835	5	\$ 121,069	18
19	Vehicles	15,138	15,138		(15,138)		15,138	19
20	<b>TOTAL (lines 18 and 19)</b>	\$ 164,212	\$ 15,138	\$ 7,835	(7,303)		\$ 136,207	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	<b>TOTALS (lines 21, 22 and 23)</b>	\$	\$	\$	24

Prairie Crossing  
 12/31/2018  
 5A

Improvement Type	Year Constructed	Cost	Book Dep.	Years in Life	S.L. Dep.	Adjustments	Acc. Dep.
Carpet	2018	10,395		5	520	520	520
PTAC units	2018	8,142		5	950	950	950
		<u>18,537</u>			<u>1,470</u>	<u>1,470</u>	<u>1,470</u>

Facility Name: Prairie Crossing

Report Period Beginning: 01/01/2018

Ending: 2/31/2018

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

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

9. Rental amount for movable equipment \$ N/A

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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1		Capital One		X	Mortgage	1/1/16	\$ 2,706,120	\$ 2,593,392	2/1/51	0.0371	\$ 16,824	1
2						/ /			/ /			2
3						/ /			/ /			3
<b>Working Capital</b>												
4						/ /			/ /			4
5						/ /			/ /			5
6		Security Deposit Interest				/ /			/ /			34
7		<b>TOTAL Facility Related</b>					\$ 2,706,120	\$ 2,593,392			\$ 16,858	7
<b>B. Non-Facility Related</b>												
8						/ /	Nonallowable Interest Expense		/ /			(34)
9						/ /	Amortization of Loan Costs		/ /			1,864
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,706,120	\$ 2,593,392			\$ 18,688	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: **01/01/2018**

Ending:

**12/31/2018****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2018

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 135,632	\$ 170,587	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0 )	141,420	144,966	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,633	9,814	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		49,591	8
9	Other(specify): <b>See Schedule 7A</b>	217,781	343,960	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 499,466	\$ 718,918	10
	<b>B. Long-Term Assets</b>			
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	96,329	15
16	Equipment, at Historical Cost	26,064	164,212	16
17	Accumulated Depreciation (book methods)	(34,992)	(1,177,565)	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): <b>See Sch 7A</b>	469,778	1,069,778	22
23	Other(specify): <b>Mortgage Costs</b>		59,602	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 502,128	\$ 2,851,407	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,001,594	\$ 3,570,325	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 7,058	\$ 7,058	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,998	22,998	30
31	Accrued Taxes Payable	42,250	68,600	31
32	Accrued Interest Payable		8,018	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>See Schedule 7A</b>	49,210	164,884	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 121,516	\$ 271,558	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		2,593,392	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$ 2,593,392	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 121,516	\$ 2,864,950	45
46	<b>TOTAL EQUITY</b>	\$ 880,078	\$ 705,375	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,001,594	\$ 3,570,325	47

\*(See instructions.)

Prairie Crossing  
12/31/2018

Schedule 7A

XI. Balance Sheet

B. Long-Term Assets

Line 9: Other current assets

<u>Description</u>	<u>Operating</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
1500 ESCROW - REPLACEMENT RESERVE	-	-	79,864
1501 ESCROW - INSURANCE	-	-	21,889
1502 ESCROW - MIP	-	-	14,598
1503 ESCROW - REAL ESTATE TAXES	-	-	9,826
3030 SHORT TERM LOAN EXCHANGE	217,781	217,781	
1506 ESCROW - PENDING LITIGATION	-	-	2
	<u>217,781</u>	<u>217,781</u>	<u>343,960</u>

XI. Balance Sheet

B. Long-Term Assets

Line 22: Other long-term assets

<u>Description</u>	<u>Operating</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
8811 DUE/FROM SLF BUILDING PARTNSHP	469,778	469,778	
6040.02 GOODWILL-PCA	-	-	600,000
	<u>469,778</u>	<u>469,778</u>	<u>1,069,778</u>

XI. Balance Sheet

C. Current Liabilities

Line 35: Other current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After</u>	
		<u>Operating</u>	<u>Consolidation</u>
7055 INSURANCE PREMIUMS PAYABLE	3,636	3,636	
7111 FICA WITHHOLDING	1,699	1,699	
7310 ACCRUED EXPENSES	43,875	43,875	
8812 DUE TO/FROM PCA	-	-	115,674
	<u>49,210</u>	<u>49,210</u>	<u>164,884</u>

Facility Name: Prairie Crossing

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,281,484	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,281,484</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	14,866	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 14,866</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	<b>Other Revenue</b>	<b>650</b>	<b>15</b>
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 650</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,297,000</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	306,193	19
20	Health Care/ Personal Care	300,412	20
21	General Administration	284,650	21
<b>B. Capital Expense</b>			
22	Ownership	232,504	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,123,759</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 173,241</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 173,241</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 527,428	32
33	Private Pay - Net Inpatient Revenue	749,369	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Pending</u>	4,687	35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 1,281,484</b>	<b>37</b>