

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2013  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2013)**

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> <p><b>Address:</b> <u>407 W Comanche Ave</u> <u>Shabbona</u> <u>60550</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>DeKalb</u></p> <p><b>Telephone Number:</b> ( <u>815</u> ) <u>824-8480</u> Fax # <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> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Amanda Springborn</u> <b>Telephone Number:</b> <u>(314) 925-3838</u>  <b>Email Address:</b> _____</p>	<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>01/01/2013</u> to <u>12/31/2013</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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) _____                  (Title) _____             </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____                  (Date) _____                  (Print Name and Title) _____                  (Firm Name &amp; Address) <u>McGladrey LLP</u>  <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>                  (Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u> </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 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Prairie Crossing

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**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	4,172	4,655		8,827	5
6	Double Unit	402	370		772	6
7	Other					7
8	TOTALS	4,574	5,025		9,599	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 73.05%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 79 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: 12/31/13 Fiscal Year: 12/31/13

\* 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:

01/01/2013

Ending: 12/31/2013

## 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	119,324	75,449	1,999	196,772	(20)	196,752	1
2	Housekeeping, Laundry and Maintenance	62,049	32,222	3,147	97,418		97,418	2
3	Heat and Other Utilities			39,068	39,068		39,068	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>181,373</b>	<b>107,671</b>	<b>44,214</b>	<b>333,258</b>	<b>(20)</b>	<b>333,238</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	192,304	571	273	193,148		193,148	6
7	Activities and Social Services	21,834	8,684		30,518		30,518	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>214,138</b>	<b>9,255</b>	<b>273</b>	<b>223,666</b>		<b>223,666</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	45,545		30,336	75,881	(50)	75,831	10
11	Marketing Materials, Promotions and Advertising			3,408	3,408	(3,408)		11
12	Employee Benefits and Payroll Taxes			63,776	63,776		63,776	12
13	Insurance-Property, Liability and Malpractice			29,649	29,649		29,649	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>45,545</b>		<b>127,169</b>	<b>172,714</b>	<b>(3,458)</b>	<b>169,256</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>441,056</b>	<b>116,926</b>	<b>171,656</b>	<b>729,638</b>	<b>(3,478)</b>	<b>726,160</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation					96,805	96,805	17
18	Interest			1,961	1,961	6,989	8,950	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			192,039	192,039	(192,039)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>194,000</b>	<b>194,000</b>	<b>(88,245)</b>	<b>105,755</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>441,056</b>	<b>116,926</b>	<b>365,656</b>	<b>923,638</b>	<b>(91,723)</b>	<b>831,915</b>	<b>24</b>

Facility Name: **Prairie Crossing**

Report Period Beginning **01/01/2013**

Ending:

**12/31/2013**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.98	\$ 24.75	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.64	10.26	3
4	Activity Director & Assistants	1.01	10.39	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	6.28	9.14	7
8	Dishwashers			8
9	Maintenance Workers	1.05	14.37	9
10	Housekeepers	1.70	8.72	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.20	18.23	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18.86</b>	<b>\$ 13.69</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	\$
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: N/A If yes, what is the value of those services? \$ N/A

(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).

Facility Name: **Prairie Crossing**

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**VIII. OWNERSHIP COSTS**

A. Purchase price of land 33,632 Year land was acquired 2006

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	\$	27.5	\$ 95,156	\$ 95,156	\$ 732,858	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Laundry Room		2007	12,716		27.5	462	462	3,100	6
7		Carpet		2007	4,998		27.5	182	182	1,115	7
8		Check Valve		2008	5,435		27.5	198	198	1,015	8
9		Fence		2008	2,434		15	162	162	599	9
10		Elevator Motor		2009	8,133		27.5	296	296	1,320	10
11		Carpet		2009	2,798		27.5	102	102	497	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,641,933	\$		\$ 96,558	\$ 96,558	\$ 740,504	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	\$ 100,912	\$	\$ 247	247	5	\$ 100,912	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 100,912	\$	\$ 247	247		\$ 100,912	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Prairie Crossing

Report Period Beginning: 01/01/2013

Ending: 2/31/2013

**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			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**	YES			NO	Amount of Note				
					Purpose of Loan	Date of Note	Original		Maturity Date	Interest Rate (4 Digits)		
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1							\$					\$
2						/ /			/ /			
3						/ /			/ /			
<b>Working Capital</b>												
4		Franklin Grove Living & Reh	X		Working Capital	6/30/06	500,000	161,650	Demand	0.0165	1,650	4
5		Shabbona Senior Living Cent	X		Working Capital	12/24/07	600,000	501,620	Demand	0.0165	8,730	5
6		Security Deposit Interest				/ /			/ /		311	6
7		<b>TOTAL Facility Related</b>					\$ 1,100,000	\$ 663,270			\$ 10,691	7
<b>B. Non-Facility Related</b>												
8						/ /	Security Deposit Interest Offset		/ /		(311)	8
9						/ /	Interest Income Offset		/ /		(1,430)	9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 1,100,000	\$ 663,270			\$ 8,950	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: **01/01/2013**

Ending:

**12/31/2013****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 66,778	\$ 231,632	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u> )	117,122	117,122	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,625	7,625	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Short Term Loan Exchange</b>	104,540	104,540	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 296,065	\$ 460,919	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		36,514	15
16	Equipment, at Historical Cost		100,912	16
17	Accumulated Depreciation (book methods)		(841,416)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>Deposit Option</b>	48,000	48,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 48,000	\$ 1,983,061	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 344,065	\$ 2,443,980	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 7,746	\$ 7,746	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,959	13,959	30
31	Accrued Taxes Payable	39,248	39,248	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>See Schedule 7A</b>	168,705	676,641	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 229,658	\$ 737,594	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<b>Option Deposit</b>		48,000	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$ 48,000	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 229,658	\$ 785,594	45
46	<b>TOTAL EQUITY</b>	\$ 114,407	\$ 1,658,386	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 344,065	\$ 2,443,980	47

\*(See instructions.)

Facility Name: Prairie Crossing

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 897,428	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 897,428</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	20	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 20</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,430	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 1,430</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 898,878</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	330,986	19
20	Health Care/ Personal Care	223,666	20
21	General Administration	174,986	21
<b>B. Capital Expense</b>			
22	Ownership	194,000	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>\$ 923,638</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (24,760)</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>\$ (24,760)</b>	<b>31</b>

**Prairie Crossing**  
**12/31/2013**  
**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
Green Acres Healthcare & Rehab Center, LLC	Amboy
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
<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

**Other Related Business Entities**

<u>Name</u>	<u>City</u>	<u>Type of Business</u>
SW Financial Services Co.	Skokie	Bookkeeping/Management Company
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
Shabbona Building Associates 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

Prairie Crossing  
12/31/2013  
Schedule 7A

XI. Line 35

<u>Description</u>	<u>Amount</u>	<u>Consolidated</u>
Due from Prior Owner	0	-1842
Due/From Old Owners	7,023	7,023
Insurance Premiums Payable	587	587
FICA Withholding	928	928
Accrued Expenses	6,675	6,675
Short Term Loan Exchange	151,650	161,650
Due/From SLF Building Partnership	1,842	501,620
	<u>168,705</u>	<u>676,641</u>