

FOR BHF USE					

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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>I. Facility ID Number: <u>1000060</u></p> <p>Facility Name: <u>Shabbona SLF</u></p> <p>Address: <u>407 W Comanche Ave</u> <u>Shabbona</u> <u>60550</u> <small>Number City Zip Code</small></p> <p>County: <u>DeKalb</u></p> <p>Telephone Number: (<u>815</u>) <u>824-8480</u> Fax # <u>(815) 824-2412</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>3/30/06</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____</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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u></td> <td></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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(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 Shabbona SLF

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	10,614	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 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	3,064	5,962		9,026	5
6	Double Unit	659	856		1,515	6
7	Other					7
8	TOTALS	3,723	6,818		10,541	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 80.00%

D. Indicate the number of paid bed-hold days the SLF had during this year 4 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: 12/31/12 Fiscal Year: 12/31/12

* 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: Shabbona SLF

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

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			
A. General Services								
1	Dietary and Food Purchase	120,661	108,406	1,685	230,752		230,752	1
2	Housekeeping, Laundry and Maintenance	71,822	27,293	1,117	100,232		100,232	2
3	Heat and Other Utilities			40,857	40,857		40,857	3
4	Other (specify):							4
5	TOTAL General Services	192,483	135,699	43,659	371,841		371,841	5
B. Health Care and Programs								
6	Health Care/ Personal Care	237,661	28	500	238,189		238,189	6
7	Activities and Social Services	17,789	5,851		23,640		23,640	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	255,450	5,879	500	261,829		261,829	9
C. General Administration								
10	Administrative and Clerical	54,304		50,698	105,002	(404)	104,598	10
11	Marketing Materials, Promotions and Advertising			4,304	4,304	(4,304)		11
12	Employee Benefits and Payroll Taxes			73,656	73,656		73,656	12
13	Insurance-Property, Liability and Malpractice			25,121	25,121		25,121	13
14	Other (specify):							14
15	TOTAL General Administration	54,304		153,779	208,083	(4,708)	203,375	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	502,237	141,578	197,938	841,753	(4,708)	837,045	16
Capital Expenses								
D. Ownership								
17	Depreciation			1,530	1,530	95,726	97,256	17
18	Interest			14,650	14,650	133,519	148,169	18
19	Real Estate Taxes			22,400	22,400		22,400	19
20	Rent -- Facility and Grounds			154,000	154,000	(154,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			192,580	192,580	75,245	267,825	23
24	GRAND TOTAL (Sum of lines 16 and 23)	502,237	141,578	390,518	1,034,333	70,537	1,104,870	24

Facility Name: Shabbona SLF

Report Period Beginning 01/01/2012 Ending: 12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.03	\$ 23.88	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8.97	9.98	3
4	Activity Director & Assistants	0.90	9.47	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	6.89	8.85	7
8	Dishwashers			8
9	Maintenance Workers	1.01	16.76	9
10	Housekeepers	1.68	8.56	10
11	Laundry	0.44	8.55	11
12	Managers			12
13	Other Administrative	2.03	12.84	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	22.95	\$ 12.36	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	\$
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

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: Shabbona SLF

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	\$ 637,702	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Laundry Room		2007	12,716	404	27.5	462	58	2,638	6
7		Carpet		2007	4,998	159	27.5	182	23	933	7
8		Check Valve		2008	5,435	173	27.5	198	25	817	8
9		Fence		2008	2,434	77	15	97	20	437	9
10		Elevator Motor		2009	8,133	259	27.5	296	37	1,024	10
11		Carpet		2009	2,798	89	27.5	102	13	395	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,641,933	\$ 1,161		\$ 96,493	\$ 95,332	\$ 643,946	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	\$ 369	\$ 763	394	5	\$ 100,665	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 100,912	\$ 369	\$ 763	394		\$ 100,665	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: Shabbona SLF

Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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	TOTAL				\$			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	2	3	4	6	7	8	9			
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	MB Financial Bank		X	Mortgage	12/24/07	\$ 2,320,000	\$	12/12/12	0.0825	\$ 138,918	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank		X	Working Capital	6/30/06	500,000		Demand	0.0825	14,650	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,820,000	\$			\$ 153,568	7
	B. Non-Facility Related										
8					/ /	Amortization of mortgage cost		/ /		3,656	8
9					/ /	Interest Income offset		/ /		(9,055)	9
10	TOTALS (lines 7, 8 and 9)					\$ 2,820,000	\$			\$ 148,169	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: Shabbona SLF

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 27,424	\$ 60,388	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	227,808	227,808	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	559,118	559,118	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 814,350	\$ 847,314	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		36,514	15
16	Equipment, at Historical Cost		100,912	16
17	Accumulated Depreciation (book methods)		(744,611)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 2,031,866	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 814,350	\$ 2,879,180	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,093	\$ 12,093	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,977	1,977	30
31	Accrued Taxes Payable	39,222	39,222	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Schedule 7A	1,578,839	2,170,195	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,632,131	\$ 2,223,487	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Option Deposit		16,000	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$ 16,000	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,632,131	\$ 2,239,487	45
46	TOTAL EQUITY	\$ (817,781)	\$ 639,693	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 814,350	\$ 2,879,180	47

*(See instructions.)

Facility Name: Shabbona SLF

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 911,868	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 911,868	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	9,055	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 9,055	14
D. Other Revenue (specify):			
15	Misc. Income	150	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 150	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 921,073	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	371,841	19
20	Health Care/ Personal Care	261,829	20
21	General Administration	208,083	21
B. Capital Expense			
22	Ownership	192,580	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)	\$ 1,034,333	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (113,260)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (113,260)	31

Shabbona SLF
12/31/2012
Schedule 4A

VI.A

Owners:

<u>Name</u>	<u>Ownership Interest</u>	<u>Avg. Hours per Work Week</u>	<u>Compensation</u>
Moshe Herman	80.50%	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	2.00%	N/A	N/A
TOTAL	100.00%		

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
Prairie Crossing Living & Rehab Center, LLC	Shabbona
Franklin Grove Living & Rehabilitation, LLC	Franklin Grove
Oregon Living & Rehabilitation, LLC	Oregon
<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>
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SW Financial Services Co.	Skokie	Bookkeeping/Management Company
S & E Medical Supply Co.	Skokie	Medical Supplies
*SFO Associates	Skokie	Finance Company

* This entity only relates to Prairie Crossing Living & Rehab,
Franklin Grove Living & Rehab, and Oregon Living & Rehab

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
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Cahokia Building LLC	Cahokia	Real Estate
Caseyville Property LLC	Caseyville	Real Estate
Shabbona Building Associates LLC	Shabbona	Real Estate

Franklin Grove Associates	Franklin Grove	Real Estate
Oregon Associates	Oregon	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

Shabbona SLF
12/31/2012
Schedule 7A

XI. Line 35

<u>Description</u>	<u>Amount</u>	<u>Consolidated</u>
Due from New Owner	9,124	31,362
Reimbursement Due	51,770	51,770
Due to Shabbona Healthcare	985,688	985,688
Accrued Expenses	8,675	8,675
Short Term Loan Exchange	276,544	286,544
Due to Public Aid	(7,962)	(7,962)
N/P Auto	-	559,118
Due to/From Partners	255,000	255,000
	<u>1,578,839</u>	<u>2,170,195</u>