



Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		405	1,870	2,275	8
9	SNF/PED					9
10	ICF	14,933	7,610		22,543	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,933	8,015	1,870	24,818	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.72%

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  NO

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

I. On what date did you start providing long term care at this location?

Date started 04/01/87

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 04/01/87 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 10 and days of care provided 1,870

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	160,616	8,516	3,961	173,093		173,093		173,093		1
2	Food Purchase		135,522		135,522		135,522	(2,606)	132,916		2
3	Housekeeping	175,433	56,882		232,315		232,315	219	232,534		3
4	Laundry	95,700	21,005		116,705		116,705	(5,133)	111,572		4
5	Heat and Other Utilities			76,492	76,492		76,492	1,062	77,554		5
6	Maintenance	60,134	36,156	12,767	109,057		109,057	840	109,897		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	491,883	258,081	93,220	843,184		843,184	(5,618)	837,566		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	1,080,213	38,535	105,003	1,223,751		1,223,751	(864)	1,222,887		10
10a	Therapy			227,449	227,449		227,449		227,449		10a
11	Activities	84,583	12,043	6,224	102,850		102,850		102,850		11
12	Social Services	36,863			36,863		36,863		36,863		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,201,659	50,578	345,676	1,597,913		1,597,913	(864)	1,597,049		16
	<b>C. General Administration</b>										
17	Administrative	60,375		132,355	192,730		192,730	(116,695)	76,035		17
18	Directors Fees										18
19	Professional Services			60,206	60,206		60,206	8,898	69,104		19
20	Dues, Fees, Subscriptions & Promotions			7,659	7,659		7,659	(744)	6,915		20
21	Clerical & General Office Expenses	115,710		37,496	153,206		153,206	39,257	192,463		21
22	Employee Benefits & Payroll Taxes			280,563	280,563		280,563	3,180	283,743		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,469	3,469		3,469	1	3,470		24
25	Other Admin. Staff Transportation			12,147	12,147		12,147	311	12,458		25
26	Insurance-Prop.Liab.Malpractice			7,341	7,341		7,341	436	7,777		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							9,373	9,373		27
28	<b>TOTAL General Administration</b>	176,085		541,236	717,321		717,321	(55,983)	661,338		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,869,627	308,659	980,132	3,158,418		3,158,418	(62,465)	3,095,953		29

SEE ACCOUNTANTS' COMPILATION REPORT

\*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.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Shabbona Healthcare Center

#0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			28,978	28,978		28,978	91,254	120,232			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,744	83,744		83,744	(36,611)	47,133			32
33	Real Estate Taxes			46,258	46,258		46,258	2,108	48,366			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			6,830	6,830		6,830	679	7,509			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			464,745	464,745		464,745	(241,505)	223,240			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,768		53,768		53,768		53,768			39
40	Barber and Beauty Shops			2,349	2,349		2,349		2,349			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):* <b>Nonallowable Cost</b>			37,122	37,122		37,122	(37,122)				43
44	<b>TOTAL Special Cost Centers</b>		53,768	89,294	143,062		143,062	(37,122)	105,940			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,869,627	362,427	1,534,171	3,766,225		3,766,225	(341,092)	3,425,133			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(5,133)	4		8
9	Non-Straightline Depreciation	21,537	30		9
10	Interest and Other Investment Income	(20,110)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(339)	43		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	(2,275)	43		18
19	Entertainment				19
20	Contributions	(1,620)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,320)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1)	43		24
25	Fund Raising, Advertising and Promotional	(3,063)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(22,841)	43		28
29	Other-Attach Schedule <u>See Page 5A</u>	(68,465)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (107,630)		\$	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	2	
		Amount	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)	(233,462)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (233,462)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (341,092)		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center

ID# 0032169

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense - Med A	\$ (4,052)	43	1
2	X-Ray Expense - Med A	(2,931)	43	2
3	RE Gain/Loss in Partnership	(3,162)	43	3
4	Association Fees	(1,389)	20	4
5	Management Fees	(53,460)	17	5
6	Management Fees	(2,493)	21	6
7	Replacement Tax	(978)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	<b>Total</b>	(68,465)		49

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

**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.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	19 Professional Services	\$	Shabbona Building Associates LLC	100.00%	\$ 525	\$	525	1
2	V	20 Fees, Subscriptions, & Promotions		Shabbona Building Associates LLC	100.00%	550		550	2
3	V	30 Depreciation		Shabbona Building Associates LLC	100.00%	67,784		67,784	3
4	V	32 Interest		Shabbona Building Associates LLC	100.00%	205,413		205,413	4
5	V	32 Interest Income	82,963	Shabbona Building Associates LLC	100.00%			(82,963)	5
6	V	32 Amortization of Mortgage Costs		Shabbona Building Associates LLC	100.00%	2,921		2,921	6
7	V	34 Rent - Facility and Grounds	298,935	Shabbona Building Associates LLC	100.00%			(298,935)	7
8	V	43 Other		Shabbona Building Associates LLC	100.00%	978		978	8
9	V	43 Other		Shabbona Building Associates LLC	100.00%	3,162		3,162	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 381,898			\$ 281,333	\$ *	(100,565)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare Center	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

\* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

\*\* Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 5	\$	5	15
16	V	3 Housekeeping		SW Management Co.	100.00%	219		219	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,062		1,062	17
18	V	6 Maintenance		SW Management Co.	100.00%	840		840	18
19	V	17 Administrative	132,355	SW Management Co.	100.00%	69,120		(63,235)	19
20	V	19 Professional Services		SW Management Co.	100.00%	5,531		5,531	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	95		95	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	41,750		41,750	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1		1	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	311		311	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	436		436	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	9,373		9,373	26
27	V	30 Depreciation		SW Management Co.	100.00%	1,933		1,933	27
28	V	32 Interest		SW Management Co.	100.00%	993		993	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,108		2,108	29
30	V	35 Rent - Equipment & Vehicles		SW Management Co.	100.00%	679		679	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		\$ 132,355			\$ 134,456	\$ *	2,101	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$ 195	S & E Medical Supply Co.	100.00%	\$ 764	\$	569	15
16	V	3 Housekeeping	1,050	S & E Medical Supply Co.	100.00%	1,050			16
17	V	10 Medical Supplies	1,620	S & E Medical Supply Co.	100.00%	756		(864)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								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		\$ 2,865			\$ 2,570	\$ *	(295)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$	SFO Associates	100.00%	\$ 8,162	\$ 8,162	15
16	V	32 Interest - Bonds	66,718	SFO Associates	100.00%	62,548	(4,170)	16
17	V	32 Interest - Intercompany	138,695	SFO Associates	100.00%		(138,695)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							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		\$ 205,413			\$ 70,710	\$ * (134,703)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	50.00	See Schedule 7A	4	9.00	Salary	\$ 15,660	L17,C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2.5	6.00	Salary	9,787	L21,C7	2
3											3
4											4
5											5
6											6
7	Note : All individuals work in excess of 40 hours per week.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,447		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning:

01/01/06

Ending: 12/31/06

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  NO

Name of Related Organization SW Management Co.  
 Street Address 7434 N. Skokie Blvd.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	608,840	11	\$ 89	\$ 33,215	\$ 5	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	33,215	219	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	33,215	1,062	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	33,215	840	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	33,215	5,531	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	33,215	95	6	
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	41,750	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	33,215	1	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	33,215	311	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	608,840	11	8,000	33,215	436	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	33,215	9,373	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	33,215	993	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	33,215	2,108	13	
14	35	Rent - Equipment & Vehicles	Bed Days Available	608,840	11	12,454	33,215	679	14	
15									15	
16	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	4	69,120	16
17									17	
18									18	
19	30	Depreciation	Direct Cost					1,933	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 134,456	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S & E Medical Supply Co.  
 Street Address 3100 Commercial Avenue  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number ( 847) 982-9300  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 764	1
2	3	Housekeeping	Direct Cost					1,050	2
3	10	Medical Supplies	Direct Cost					756	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									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	TOTALS				\$	\$		\$ 2,570	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SFO Associates  
 Street Address 7434 N. Skokie Blvd.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 31,207	\$ 1,700,000	\$ 8,162	1
2	32	Interest - Bonds	Note Receivable	6,500,000	3	239,155	1,700,000	62,548	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									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	TOTALS					\$ 270,362	\$	\$ 70,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Shabbona Building Assoc	X		Bonds		07/01/94	\$ 1,700,000	\$ 915,385	08/15/14	0.0665	\$ 62,548	1						
2	(Loan Payable-SFO Assoc)											2						
3	American National		X	Note Payable		11/30/06	200,000	200,000	11/30/07	0.0825	781	3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,900,000	\$ 1,115,385			\$ 63,329	9						
<b>B. Non-Facility Related*</b>																		
10							Interest income offset net of intercompany interest				(20,110)	10						
11							Amortization of loan costs				2,921	11						
12							SW Management allocation-mortgage				993	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>										\$ (16,196)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,900,000	\$ 1,115,385			\$ 47,133	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Shabbona Healthcare Center COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0032169

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-15-327-010</u>	<u>Long-term care property</u>	\$ <u>44,758.22</u>	\$ <u>44,758.22</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management allocation</u>	\$ <u>39,720.37</u>	\$ <u>2,108.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>84,478.59</u>	\$ <u>46,866.22</u>

**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?        YES   X   NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (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?  (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  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>			\$ <u>50,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>50,000</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	91	1994		\$ 2,643,587	\$	39	\$ 67,784	\$ 67,784	\$ 844,555	4
5										5
6	Allocation from Management Co.	1995		23,900		39	683	683	7,959	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1989	2,650	84	20		(84)	2,650	9
10	Various		1990	65,810	1,200	20	3,291	2,091	54,584	10
11	Various		1991	20,535	460	20	922	462	17,273	11
12	Various		1992	5,466		10			4,191	12
13	Various		1993	13,848	393	20	685	292	9,167	13
14	Various		1994	39,334	1,009	20	1,967	958	25,142	14
15	Various		1995	13,479	178	20	674	496	8,780	15
16	Various		1996	11,533	160	20	577	417	6,926	16
17	Various		1997	18,996	487	20	950	463	9,311	17
18	Various		1998	141,664	3,693	20	7,021	3,328	62,405	18
19	Various		1999	2,415	62	20	121	59	927	19
20	Air Handler		2000	1,150		10	115	115	767	20
21	Air Handler		2000	1,870		10	187	187	1,231	21
22	Air Handler		2000	1,900		10	190	190	1,235	22
23	Driveway		2001	3,040	78	20	152	74	798	23
24	Nurses Call System		2001	2,745		10	275	275	1,511	24
25	Air Handler		2001	1,350		10	135	135	776	25
26	Security System		2001	1,507		10	151	151	803	26
27	Telephone System		2001	1,928		10	193	193	1,016	27
28	Heating and Cooling System		2002	1,078		20	54	54	247	28
29	Drapes		2003	1,528		10	153	153	573	29
30	Sidewalk Repair		2003	1,250		20	63	63	219	30
31	Wallpaper - North Dining Hall		2004	3,007	109	20	150	41	376	31
32	Air Handlers		2005	6,391	232	20	320	88	479	32
33	Windows, fascia and gutters & oversize downspouts		2005	60,785	2,210	20	3,039	829	4,559	33
34	Security control panel		2005	688	25	20	34	9	51	34
35	Patio & Fountain		2006	18,668	933	20	467	(466)	467	35
36	Fence		2006	2,008	100	20	50	(50)	50	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2006	\$ 1,826	\$ 14	10	\$ 91	\$ 77	\$ 91	37
38	2006	5,392	123	20	135	12	135	38
39	2006	4,200	210	20	105	(105)	105	39
40	2006	99,698	4,985	20	2,492	(2,493)	2,492	40
41								41
42	1995	2,550		20	127	127	1,666	42
43	1996	445		20	22	22	235	43
44	1997	641		20	32	32	384	44
45	1998	441		20	22	22	193	45
46	1999	1,226		20	61	61	434	46
47	2005	2,536		20	127	127	190	47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 3,233,065	\$ 16,745		\$ 93,614	\$ 76,869	\$ 1,074,954	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 107,261	\$ 4,883	\$ 15,461	\$ 10,578	10	\$ 79,911	71
72	Current Year Purchases	19,400	2,725	681	(2,044)	10	681	72
73	Fully Depreciated Assets	297,946					297,946	73
74	Allocation from Management Co.	6,451		218	218	10	6,107	74
75	TOTALS	\$ 431,058	\$ 7,608	\$ 16,360	\$ 8,752		\$ 384,645	75

D. Vehicle Depreciation (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	1995	\$ 21,506	\$	\$	\$	5	\$ 20,982	76
77	Resident Care	2001 Grand Jeep	2001	33,668	1,775	4,489	2,714	5	28,866	77
78	Resident Care	2004 Jeep	2004	25,644	2,850	5,129	2,279	5	12,822	78
79	Allocation from Mgmt Co	2004 Cadillac	2004	3,201		640	640	5	1,600	79
80	TOTALS			\$ 84,019	\$ 4,625	\$ 10,258	\$ 5,633		\$ 64,270	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)		\$ 3,798,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 28,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 120,232	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 91,254	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,523,870	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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:				\$ _____			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: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 6,830 Description: \$4,897 RK Dixon Co, & \$1,933 Tool Time Rental

(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	<u>SW Management Allocation</u>		\$ _____	\$ <u>679</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>679</u>	21

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	8,100	\$ 101,892	\$	8,100	\$ 101,892	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,393	17,527		1,393	17,527	2
3	Licensed Recreational Therapist	L10A, C3	hrs		8,594	108,030		8,594	108,030	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				53,768		53,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	18,087	\$ 227,449	\$ 53,768	18,087	\$ 281,217	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Shabbona Healthcare Center**

# **0032169**

Report Period Beginning: **01/01/06**

Ending:

**12/31/06**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/06**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (49,382)	\$ (49,382)	1
2	Cash-Patient Deposits	136	136	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	769,002	769,002	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,143	2,143	6
7	Other Prepaid Expenses		643	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	(1,023,110)	449,823	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (301,211)	\$ 1,172,365	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,643,587	14
15	Leasehold Improvements, at Historical Cost	519,767	589,478	15
16	Equipment, at Historical Cost	331,051	515,077	16
17	Accumulated Depreciation (book methods)	(413,440)	(1,523,870)	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): <u>See Schedule 17A</u>		76,215	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 437,378	\$ 2,350,487	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 136,167	\$ 3,522,852	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 117,833	\$ 117,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,808	1,808	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	73,040	73,040	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,959	12,959	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,000	46,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	43,213	2,442,852	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 494,853	\$ 2,894,492	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		915,385	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 915,385	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 494,853	\$ 3,809,877	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (358,686)	\$ (287,025)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 136,167	\$ 3,522,852	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Shabbona Healthcare Center, Inc.  
 Provider #:0032169  
 12/31/2005

Schedule 17A

XV. BALANCE SHEET -

<b>Other Current Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due from State-Interest	7,153	7,153
Employee Loans	16,167	16,167
Short Term Loan Exchange	4,145	4,145
Due from The Meadows Ret. Center	422,358	422,358
Due/from Shabbona LLC	#####	(1,472,933)
Due to Shabbona Healthcare	-	1,472,933
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>(1,023,110)</b>	<b>449,823</b>

<b>Other (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Investment in SFO	-	25,167
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(36,568)
<b>Total Line 22 - Other Current Liabilities (specify):</b>	<b>-</b>	<b>76,215</b>

<b>Other Long-Term Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Insurance Premiums Payable	583	583
Accrued Expenses	42,630	42,630
Due to/From - SFO	-	2,399,639
<b>Total Line 36 - Other Long-Term Liabilities (specify):</b>	<b>43,213</b>	<b>2,442,852</b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(106,728)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Variance</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(106,725)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(251,961)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(251,961)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(358,686)</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,299,817	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,299,817	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,502	6
7	Oxygen	(528)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 172,974	8
	<b>C. Other Operating Revenue</b>		
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	2,307	13
14	Non-Patient Meals		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	12,784	21
22	Laundry	5,133	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 20,224	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	19,566	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19,566	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Finance Charges	544	28
28a	Miscellaneous Income	1,139	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,683	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,514,264	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	843,184	31
32	Health Care	1,597,913	32
33	General Administration	717,321	33
	<b>B. Capital Expense</b>		
34	Ownership	464,745	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	93,239	35
36	Provider Participation Fee	49,823	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,766,225	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(251,961)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (251,961)	43

\* 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.  
This entity is a cash basis tax payer.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Shabbona Healthcare Center**

# **0032169**

Report Period Beginning:

**01/01/06**

Ending:

**12/31/06**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,200	2,200	\$ 59,005	\$ 26.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,732	4,371	104,762	23.97	3
4	Licensed Practical Nurses	12,105	13,581	293,679	21.62	4
5	CNAs & Orderlies	54,427	59,420	622,767	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,504	8,307	84,583	10.18	10
11	Social Service Workers	2,506	2,564	36,863	14.38	11
12	Dietician					12
13	Food Service Supervisor	2,201	2,360	24,818	10.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,191	16,952	135,798	8.01	15
16	Dishwashers					16
17	Maintenance Workers	3,843	3,957	60,134	15.20	17
18	Housekeepers	18,413	19,680	175,433	8.91	18
19	Laundry	11,789	12,207	95,700	7.84	19
20	Administrator	2,000	2,080	60,375	29.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,208	6,949	115,710	16.65	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)	143,119	154,628	\$ 1,869,627 *	\$ 12.09	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	99	\$ 3,961	L1, C3	35
36	Medical Director	350	7,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	70	3,340	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	130	6,224	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	649	\$ 20,525		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,675	\$ 101,663	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,675	\$ 101,663		53

SEE ACCOUNTANTS' COMPILATION REPORT



**Shabbona Healthcare Center, Inc.**

**Provider #: 0032169**

**01/01/2005 to 12/31/2005**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	60,206
Out of Period Legal	(5,320)
Allocated from Shabbona Building Associates LLC <b>Accounting</b>	525
Allocated from SFO Associates <b>Accounting</b>	8,162
Allocated from Management Company <b>Legal</b>	4,557
<b>Accounting - RSM McGladrey</b>	974
Total (agree to Schedule V, line 19, column 8)	<u>69,104</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center# 0032169Report Period Beginning: 01/01/06Ending: 12/31/06**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 LTC : \$2,064
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,351 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. \$ 49,823  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 3,180 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**  
**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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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