



Facility Name Shabbona Supportive Living Facility

Report Period Beginning: 01/01/07 Ending: 12/31/07

**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	1,622	4,036	1,076	6,734	5
6	Double Unit	950	1,260		2,210	6
7	Other					7
8	TOTALS	2,572	5,296	1,076	8,944	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 68.07%

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

**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: 12/31/07 Fiscal Year: 12/31/07

\* 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

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	80,996	65,122	1,547	147,665	(48)	147,617	1
2	Housekeeping, Laundry and Maintenance	64,288	35,434	1,115	100,837		100,837	2
3	Heat and Other Utilities			37,222	37,222		37,222	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>145,284</b>	<b>100,556</b>	<b>39,884</b>	<b>285,724</b>	<b>(48)</b>	<b>285,676</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	223,350	215	1,000	224,565		224,565	6
7	Activities and Social Services	60,771	1,047		61,818		61,818	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>284,121</b>	<b>1,262</b>	<b>1,000</b>	<b>286,383</b>		<b>286,383</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	5,739		32,814	38,553	5,928	44,481	10
11	Marketing Materials, Promotions and Advertising			18,416	18,416	(18,416)		11
12	Employee Benefits and Payroll Taxes			56,697	56,697		56,697	12
13	Insurance-Property, Liability and Malpractice			26,036	26,036		26,036	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>5,739</b>		<b>133,963</b>	<b>139,702</b>	<b>(12,488)</b>	<b>127,214</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>435,144</b>	<b>101,818</b>	<b>174,847</b>	<b>711,809</b>	<b>(12,536)</b>	<b>699,273</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			5,198	5,198	123,208	128,406	17
18	Interest			63,196	63,196	162,616	225,812	18
19	Real Estate Taxes			47,093	47,093		47,093	19
20	Rent -- Facility and Grounds			166,000	166,000	(166,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>281,487</b>	<b>281,487</b>	<b>119,824</b>	<b>401,311</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>435,144</b>	<b>101,818</b>	<b>456,334</b>	<b>993,296</b>	<b>107,288</b>	<b>1,100,584</b>	<b>24</b>

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.53	\$ 23.42	1
2	Licensed Practical Nurses	0.79	24.03	2
3	Certified Nurse Assistants	7.08	10.72	3
4	Activity Director & Assistants	0.85	10.46	4
5	Social Service Workers	1.00	20.34	5
6	Head Cook	1.07	10.87	6
7	Cook Helpers/Assistants	3.36	8.14	7
8	Dishwashers			8
9	Maintenance Workers	0.97	12.98	9
10	Housekeepers	1.27	7.80	10
11	Laundry	1.08	7.74	11
12	Managers			12
13	Other Administrative			13
14	Clerical	0.29	9.57	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18.29</b>	<b>\$ 10.99</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	Albert Milstein	45%		\$	1
2	Sheldon Wolfe	43%	0.5		2
3	Mo Herman	10%	0.5		3
4	Jeremy Amster	2%			4
5					5
<b>Total</b>				<b>\$ None</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

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

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See attached schedule 4A			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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

Name of related entity: \_\_\_\_\_ If yes, what is the value of those services? \$ \_\_\_\_\_  
 (Please attach a separate schedule itemizing those services.)

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

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

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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	\$ 2,605,418	\$ 95,017	27.50	\$ 95,017	\$	\$ 160,795	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Laundry Room		2007	12,716	328	27.50	328		328	6
7		Carpet		2007	4,998	23	27.50	23		23	7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,623,132	\$ 95,368		\$ 95,368	\$	\$ 161,146	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	\$ 33,038	\$ 33,038	\$	5	\$ 47,026	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 100,912	\$ 33,038	\$ 33,038	\$		\$ 47,026	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

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

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

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

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

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

**X. INTEREST EXPENSE**

	1	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				
	<b>A. Directly Facility Related Long-Term</b>										
1	MB Financial Bank		X	Mortgage	12/24/07	\$ 2,320,000	\$ 2,320,000	1/15/08	8.2500	\$ 196,616	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4	MB Financial Bank	X		Working Capital	6/30/06	500,000	500,000	Demand	8.2500	63,196	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 2,820,000	\$ 2,820,000			\$ 259,812	7
	<b>B. Non-Facility Related</b>										
8					/ /	Interest Income offset		/ /		-34,000	8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,820,000	\$ 2,820,000			\$ 225,812	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.



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**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	\$ 753,756	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 753,756	3
<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	48	9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 48	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	34,000	13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 34,000	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 787,804	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	285,724	19
20	Health Care/ Personal Care	286,383	20
21	General Administration	139,702	21
<b>B. Capital Expense</b>			
22	Ownership	281,487	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 993,296	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (205,492)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (205,492)	31

Shabbona SLF

12/31/2007

Related Organizations

**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 and Rehab	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.

Shabbona Supportive Living Facility

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Schedule 7A

XI. Line 35

<b><u>Description</u></b>	<b><u>Amount</u></b>	<b><u>Consolidated</u></b>
Due to Shabbona Healthcare	(475,783)	(475,783)
FICA Withholding	(1,590)	(1,590)
Short Term Loan Exchange	-	(10,000)
N/P Auto	10,822	(447,677)
Due/From SLF Building	458,908	458,908
Due To/From Partners	(255,000)	(255,000)
	<u>(262,643)</u>	<u>(731,142)</u>