



Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		450	2,680	3,130	8
9	SNF/PED					9
10	ICF	15,703	6,428		22,131	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,703	6,878	2,680	25,261	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.05%

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  Note: 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 04/01/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/1987 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 2,680

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

\* 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: 01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	158,719	9,152	3,730	171,601		171,601		171,601		1
2	Food Purchase		141,558		141,558		141,558	(2,192)	139,366		2
3	Housekeeping	179,820	49,468		229,288		229,288	99	229,387		3
4	Laundry	94,113	24,667		118,780		118,780	(5,743)	113,037		4
5	Heat and Other Utilities			100,523	100,523		100,523	910	101,433		5
6	Maintenance	51,740	22,522	13,149	87,411		87,411	1,173	88,584		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	484,392	247,367	117,402	849,161		849,161	(5,753)	843,408		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,056,851	49,603	124,037	1,230,491		1,230,491	(1,233)	1,229,258		10
10a	Therapy			219,955	219,955		219,955		219,955		10a
11	Activities	69,343	17,752	5,450	92,545		92,545		92,545		11
12	Social Services	48,233			48,233		48,233		48,233		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,174,427	67,355	349,442	1,591,224		1,591,224	(1,233)	1,589,991		16
	<b>C. General Administration</b>										
17	Administrative	46,491		130,125	176,616		176,616	(112,100)	64,516		17
18	Directors Fees										18
19	Professional Services			43,593	43,593		43,593	14,584	58,177		19
20	Dues, Fees, Subscriptions & Promotions			11,034	11,034		11,034	(927)	10,107		20
21	Clerical & General Office Expenses	122,438		36,824	159,262		159,262	21,753	181,015		21
22	Employee Benefits & Payroll Taxes			248,248	248,248		248,248	3,088	251,336		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,660	2,660		2,660	(453)	2,207		24
25	Other Admin. Staff Transportation			9,768	9,768		9,768	407	10,175		25
26	Insurance-Prop.Liab.Malpractice			7,611	7,611		7,611	383	7,994		26
27	Other (specify):*							7,610	7,610		27
28	<b>TOTAL General Administration</b>	168,929		489,863	658,792		658,792	(65,655)	593,137		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,827,748	314,722	956,707	3,099,177		3,099,177	(72,641)	3,026,536		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			39,903	39,903		39,903	76,001	115,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,652	113,652		113,652	(72,455)	41,197			32
33	Real Estate Taxes			48,340	48,340		48,340	2,128	50,468			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			4,271	4,271		4,271	641	4,912			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			505,101	505,101		505,101	(292,620)	212,481			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,084		67,084		67,084		67,084			39
40	Barber and Beauty Shops			1,390	1,390		1,390		1,390			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):* <b>Non-allowable Cos</b>			36,412	36,412		36,412	(36,412)				43
44	<b>TOTAL Special Cost Centers</b>		67,084	87,625	154,709		154,709	(36,412)	118,297			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,827,748	381,806	1,549,433	3,758,987		3,758,987	(401,673)	3,357,314			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	BHF 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	(5,743)	4		8
9	Non-Straightline Depreciation	6,544	30		9
10	Interest and Other Investment Income	(131,567)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	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				18
19	Entertainment				19
20	Contributions	(1,909)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(773)	43		24
25	Fund Raising, Advertising and Promotional	(4,717)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,240)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(21,736)	43		28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(10,513)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (171,961)		\$	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)	(229,712)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (229,712)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (401,673)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Association Fees	\$ (1,160)	20	1
2	Lab Expense-Med A	(4,758)	43	2
3	X-Ray Expense-Med A	(2,213)	43	3
4	Bank Service Charge	1	43	4
5	Gain/Loss in Partnership	(1,898)	43	5
6	Travel and Seminar	(485)	24	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
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27				27
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29				29
30				30
31				31
32				32
33				33
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>	(10,513)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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%	\$ 2,475	\$ 2,475	1
2	V	20 Fees, Subscriptions, & Promotions		Shabbona Building Associates LLC	100.00%	190	190	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%	206,667	206,667	4
5	V	32 Amortization of Mortgage Costs		Shabbona Building Associates LLC	100.00%	2,921	2,921	5
6	V	34 Rent-Facility and Grounds	298,935	Shabbona Building Associates LLC	100.00%		(298,935)	6
7	V	43 Other		Shabbona Building Associates LLC	100.00%	3,138	3,138	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 298,935			\$ 283,175	\$ * (15,760)	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%	\$ 16	\$	16	15
16	V	3 Housekeeping		SW Management Co.	100.00%	99		99	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	910		910	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,173		1,173	18
19	V	17 Administrative	130,125	SW Management Co.	100.00%	18,025		(112,100)	19
20	V	19 Professional Services		SW Management Co.	100.00%	5,552		5,552	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	43		43	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	21,753		21,753	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	32		32	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	407		407	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	383		383	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	7,610		7,610	26
27	V	30 Depreciation		SW Management Co.	100.00%	1,673		1,673	27
28	V	32 Interest		SW Management Co.	100.00%	885		885	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,128		2,128	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	641		641	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		\$ 130,125			\$ 61,330	\$ *	(68,795)	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	\$	S & E Medical Supply Co.	100.00%	\$ 880	\$ 880	15
16	V	10 Medical Supplies	2,113	S & E Medical Supply Co.	100.00%	880	(1,233)	16
17	V							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		\$ 2,113			\$ 1,760	\$ * (353)	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%	\$ 6,557	\$ 6,557
16	V	32 Interest-Bonds	61,380	SFO Associates	100.00%	55,306	(6,074)
17	V	32 Interest-Intercompany	145,287	SFO Associates	100.00%		(145,287)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 206,667			\$ 61,863	\$ * (144,804)

\* 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:

01/01/2007

Ending:

12/31/2007

## 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	2	9.00	Salary	\$ 9,013	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2	6.00	Salary	9,013	L17, 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	\$ 18,026		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: 01/01/2007

Ending: 2/31/2007

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	645,320	11	\$ 319	\$ 33,215	\$ 16	1
2	3	Housekeeping	Bed Days Available	645,320	11	1,918	33,215	99	2
3	5	Heat and Other Utilities	Bed Days Available	645,320	11	17,688	33,215	910	3
4	6	Maintenance	Bed Days Available	645,320	11	22,780	33,215	1,173	4
5	19	Professional Services	Bed Days Available	645,320	11	107,864	33,215	5,552	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	645,320	11	844	33,215	43	6
7	21	Clerical & General Office Exp	Bed Days Available	645,320	11	422,637	373,471	21,753	7
8	24	Travel and Seminar	Bed Days Available	645,320	11	625	33,215	32	8
9	25	Other Admin. Staff Transport	Bed Days Available	645,320	11	7,906	33,215	407	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	645,320	11	7,442	33,215	383	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	645,320	11	147,860	33,215	7,610	11
12	32	Interest	Bed Days Available	645,320	11	17,198	33,215	885	12
13	33	Real Estate Taxes	Bed Days Available	645,320	11	41,339	33,215	2,128	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	645,320	11	12,453	33,215	641	14
15									15
16	17	Administrative	Avg. Hours Worked	40	11	360,500	2	18,025	16
17									17
18	30	Depreciation	Direct Cost			32,495		1,673	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,201,868	\$ 373,471	\$ 61,330	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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		\$	\$		\$ 880	1
2	10	Medical Supplies	Direct Cost					880	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				\$	\$		1,760	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

# 0032169 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 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

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	19	Professional Services	Note Receivable	6,500,000	3	\$ 25,069	\$ 1,700,000	\$ 6,557	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	211,466	1,700,000	55,306	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					\$ 236,535	\$	\$ 61,863	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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	\$ 810,769	08/15/14	0.0665	\$ 55,306	1						
2	(Loan Payable-SFO Assoc)											2						
3	American National		X	Note Payable		11/30/06	300,000	300,000	11/30/08	0.0825	22,414	3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 2,000,000	\$ 1,110,769			\$ 77,720	9						
<b>B. Non-Facility Related*</b>																		
10							Interest income offset net of intercompany interest				(40,329)	10						
11							Amortization of loan costs				2,921	11						
12							SW Management allocation-mortgage				885	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (36,523)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,000,000	\$ 1,110,769			\$ 41,197	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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>46,000</b>	1
	Allocation from Management Co.		<b>2,128</b>	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>46,340</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>340</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,468</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<b>41,710</b>	8	
	2003	<b>42,643</b>	9	
	2004	<b>43,252</b>	10	
	2005	<b>44,758</b>	11	
	2006	<b>46,340</b>	12	
<b>2006 Tax Accrual = 46,340 X 1.03 = 47,730. Use 48,000.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>46,340.34</u>	\$ <u>46,340.34</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>42,503.98</u>	\$ <u>2,128.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>88,844.32</u>	\$ <u>48,468.34</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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.

Facility Name & ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**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:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Shabbona Healthcare Center

# 0032169

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$ 912,336	4
5										5
6	Allocation from Management Co.	1995		22,278		39	637	637	8,055	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	57,874	10
11	Various		1991	20,535	460	20	725	265	17,998	11
12	Various		1992	5,466		10			4,191	12
13	Various		1993	13,848	393	20	685	292	9,852	13
14	Various		1994	39,334	1,009	20	1,967	958	27,109	14
15	Various		1995	13,479	178	20	674	496	9,454	15
16	Various		1996	11,533	160	20	577	417	7,503	16
17	Various		1997	18,996	487	20	950	463	10,261	17
18	Various		1998	141,664	3,693	20	7,021	3,328	69,426	18
19	Various		1999	2,415	62	20	121	59	1,048	19
20	Air Handler		2000	1,150		10	115	115	882	20
21	Air Handler		2000	1,870		10	187	187	1,418	21
22	Air Handler		2000	1,900		10	190	190	1,425	22
23	Driveway		2001	3,040	78	20	152	74	950	23
24	Nurses Call System		2001	2,745		10	275	275	1,785	24
25	Air Handler		2001	1,350		10	135	135	911	25
26	Security System		2001	1,507		10	151	151	954	26
27	Telephone System		2001	1,928		10	193	193	1,209	27
28	Heating and Cooling System		2002	1,078		20	54	54	301	28
29	Drapes		2003	1,528		10	153	153	726	29
30	Sidewalk Repair		2003	1,250		20	63	63	281	30
31	Wallpaper - North Dining Hall		2004	3,007	109	20	150	41	527	31
32	Air Handlers		2005	6,391	232	20	320	88	799	32
33	Windows, fascia and gutters & oversize downspouts		2005	60,785	2,210	20	3,039	829	7,598	33
34	Security control panel		2005	688	25	20	34	9	86	34
35	Patio & Fountain		2006	18,666	1,773	20	933	(840)	1,400	35
36	Fence		2006	2,008	191	20	100	(91)	151	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	2	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	3 Glass Doors	2006	\$ 1,826	\$ 66	10	\$ 183	\$ 117	\$ 274	37
38	Fire Alarm System	2006	5,392	196	20	270	74	404	38
39	Asphalt	2006	4,200	399	20	210	(189)	315	39
40	Landscaping	2006	99,698	9,471	20	4,985	(4,486)	7,477	40
41	Kitchen Air Conditioners	2007	5,193	1,039	20	130	(909)	130	41
42									42
43									43
44									44
45									45
46									46
47									47
48	Allocation from SW management - leasehold improvements	1995	2,377		20	119	119	1,672	48
49	Allocation from SW management - leasehold improvements	1996	415		20	21	21	240	49
50	Allocation from SW management - leasehold improvements	1997	598		20	30	30	388	50
51	Allocation from SW management - leasehold improvements	1998	412		20	21	21	201	51
52	Allocation from SW management - leasehold improvements	1999	1,143		20	57	57	462	52
53	Allocation from SW management - leasehold improvements	2005	2,364		20	118	118	295	53
54	Allocation from SW management - leasehold improvements	2007	1,338		20	33	33	33	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	TOTAL (lines 4 thru 69)		\$ 3,237,442	\$ 23,515		\$ 96,850	\$ 73,335	\$ 1,171,050	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 108,733	\$ 6,379	\$ 11,649	\$ 5,270	10	\$ 80,090	71
72	Current Year Purchases	32,791	6,559	1,640	(4,919)	10	1,640	72
73	Fully Depreciated Assets	310,099					310,099	73
74	Allocation from Management Co.	6,017		40	40	10	5,067	74
75	TOTALS	\$ 457,640	\$ 12,938	\$ 13,329	\$ 391		\$ 396,896	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	1998	\$ 21,506	\$	\$	\$	5	\$ 20,982	76
77	Resident Care	2001 Grand Jeep	2001	33,668	1,775		(1,775)	5	28,866	77
78	Resident Care	2004 Jeep	2004	25,644	1,675	5,129	3,454	5	17,951	78
79	Allocation from Mgmt Co.	2004 Cadillac	2004	2,985		597	597	5	2,089	79
80	TOTALS			\$ 83,803	\$ 3,450	\$ 5,726	\$ 2,276		\$ 69,888	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)	\$ 3,828,885	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,903	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,904	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 76,001	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,637,834	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: \$ 4,271 Description: Copier - 4271

(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>641</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>641</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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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	\$	3,442	\$ 96,374	\$	3,442	\$ 96,374	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		316	19,049		316	19,049	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,909	101,623		3,909	101,623	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				67,084		67,084	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>			\$	7,667	\$ 217,046	\$ 67,084	7,667	\$ 284,130	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: **01/01/2007**

Ending:

**12/31/2007**

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

As of **12/31/2007**

(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	\$ 22,060	\$ 22,060	1
2	Cash-Patient Deposits	3,491	3,491	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	898,154	898,154	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,140	2,140	6
7	Other Prepaid Expenses		608	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	497,901	497,901	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,423,746	\$ 1,424,354	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	524,960	593,855	15
16	Equipment, at Historical Cost	358,067	541,443	16
17	Accumulated Depreciation (book methods)	(453,343)	(1,637,834)	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 Sch. 17A)</u>		71,396	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 429,684	\$ 2,262,447	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,853,430	\$ 3,686,801	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 59,545	\$ 59,545	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,063	1,063	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	82,116	82,116	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,173	10,173	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000	48,000	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>	1,719,374	2,571,060	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,220,271	\$ 3,071,957	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		810,769	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>	\$	\$ 810,769	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,220,271	\$ 3,882,726	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (366,841)	\$ (195,925)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,853,430	\$ 3,686,801	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Shabbona Healthcare Center, Inc.  
 Provider #:0032169  
 12/31/2007

Schedule 17A

XV. BALANCE SHEET -

<b>Other Current Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due from State-Interest	4,165	4,165
Employee Loans	16,625	16,625
Employee Payroll Advance	600	600
Reimbursement Due	728	728
Due from Shabbona Ret Cnt	475,783	475,783
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>497,901</b>	<b>497,901</b>

<b>Other (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Investment in SFO	-	23,269
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(39,489)
<b>Total Line 22 - Other Current Liabilities (specify):</b>	<b>-</b>	<b>71,396</b>

<b>Other Current Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Acc. Retirement (From P/R)	150	150
Accrued Expenses	(59,939)	(59,939)
Due to/From - SFO	-	(2,511,271)
RE due to Shabbona Healthcare	-	1,659,585
Due/From Shabbona LLC	#####	(1,659,585)
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>(1,719,374)</b>	<b>(2,571,060)</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>(358,685)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</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>(358,685)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(8,156)</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>(8,156)</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>(366,841)</b>	<b>24</b> *

\* 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	\$ 3,547,408	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,547,408	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,808	6
7	Oxygen	(3,298)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 139,510	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	2,246	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	15,592	21
22	Laundry	5,743	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,581	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	37,665	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 37,665	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Finance charge revenue</u>	2,667	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,667	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,750,831	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	849,161	31
32	Health Care	1,591,224	32
33	General Administration	658,792	33
<b>B. Capital Expense</b>			
34	Ownership	505,101	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	104,886	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>	\$ 3,758,987	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(8,156)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (8,156)	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 taxpayer.

\*\*\* 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: **01/01/2007**

Ending:

**12/31/2007**

**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	2,016	2,080	\$ 63,600	\$ 30.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,029	3,544	88,993	25.11	3
4	Licensed Practical Nurses	11,386	12,486	297,745	23.85	4
5	CNAs & Orderlies	52,278	56,929	606,513	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,348	6,965	69,343	9.96	10
11	Social Service Workers	2,737	2,873	48,233	16.79	11
12	Dietician					12
13	Food Service Supervisor	2,488	2,619	30,237	11.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,731	15,512	128,482	8.28	15
16	Dishwashers					16
17	Maintenance Workers	2,856	2,961	51,740	17.47	17
18	Housekeepers	18,146	19,437	179,820	9.25	18
19	Laundry	11,553	11,949	94,113	7.88	19
20	Administrator	1,440	1,440	46,491	32.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,199	6,872	122,438	17.82	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)	135,207	145,667	\$ 1,827,748 *	\$ 12.55	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	93	\$ 3,730	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	111	5,330	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	61	2,909	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	114	5,450	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	379	\$ 17,419		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,124	\$ 118,707	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,124	\$ 118,707		53

SEE ACCOUNTANTS' COMPILATION REPORT



**Shabbona Healthcare Center, Inc.**

**Provider #: 0032169**

**1/1/2007 to 12/31/2007**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	43,593
Allocated from Shabbona Building Associates LLC	
<b>Accounting</b>	2,475
Allocated from SFO Associates	
<b>Accounting</b>	6,557
Allocated from Management Company	
<b>Legal</b>	4,048
<b>Accounting - RSM McGladrey</b>	1,504
Total (agree to Schedule V, line 19, column 8)	<u>58,177</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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
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: 01/01/2007Ending: 12/31/2007**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 : \$3,345
- (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. \$ 15,999 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. \$ 3,088 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 \$5,000, 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