

Facility Name & ID Number Shabbona Healthcare Center

0032169 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	33,306	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	33,306	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	14	420	1,917	2,351	8
9	SNF/PED					9
10	ICF	14,522	9,113		23,635	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,536	9,533	1,917	25,986	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.02%

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 1,917

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
	A. General Services										
1	Dietary	170,994	10,630	6,152	187,776		187,776		187,776		1
2	Food Purchase		169,757		169,757		169,757	(2,668)	167,089		2
3	Housekeeping	200,977	50,027		251,004		251,004	73	251,077		3
4	Laundry	91,139	16,962		108,101		108,101		108,101		4
5	Heat and Other Utilities			112,779	112,779		112,779	712	113,491		5
6	Maintenance	46,272	37,643	17,108	101,023		101,023	1,571	102,594		6
7	Other (specify):*										7
8	TOTAL General Services	509,382	285,019	136,039	930,440		930,440	(312)	930,128		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,057,383	58,864	207,179	1,323,426		1,323,426	(1,539)	1,321,887		10
10a	Therapy			190,378	190,378		190,378		190,378		10a
11	Activities	94,876	21,414	4,702	120,992		120,992		120,992		11
12	Social Services	32,674			32,674		32,674		32,674		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,184,933	80,278	402,259	1,667,470		1,667,470	(1,539)	1,665,931		16
	C. General Administration										
17	Administrative	65,256		130,125	195,381		195,381	(111,565)	83,816		17
18	Directors Fees										18
19	Professional Services			84,028	84,028		84,028	(372)	83,656		19
20	Dues, Fees, Subscriptions & Promotions			10,813	10,813		10,813	(3,358)	7,455		20
21	Clerical & General Office Expenses	131,210		40,202	171,412		171,412	24,180	195,592		21
22	Employee Benefits & Payroll Taxes			270,824	270,824		270,824	3,649	274,473		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,390	6,390		6,390	(482)	5,908		24
25	Other Admin. Staff Transportation			15,205	15,205		15,205	721	15,926		25
26	Insurance-Prop.Liab.Malpractice			54,283	54,283		54,283	341	54,624		26
27	Other (specify):* Mgmt Alloc of Benefit							9,034	9,034		27
28	TOTAL General Administration	196,466		611,870	808,336		808,336	(77,852)	730,484		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,890,781	365,297	1,150,168	3,406,246		3,406,246	(79,703)	3,326,543		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.

Facility Name & ID Number

Shabbona Healthcare Center

#0032169

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	
	D. Ownership											
30	Depreciation			41,823	41,823		41,823	73,315	115,138			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,958	71,958		71,958	8,095	80,053			32
33	Real Estate Taxes							53,047	53,047			33
34	Rent-Facility & Grounds			349,859	349,859		349,859	(349,859)				34
35	Rent-Equipment & Vehicles			1,800	1,800		1,800	632	2,432			35
36	Other (specify):*											36
37	TOTAL Ownership			465,440	465,440		465,440	(214,770)	250,670			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,358		58,358		58,358		58,358			39
40	Barber and Beauty Shops			2,607	2,607		2,607		2,607			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,960	49,960		49,960		49,960			42
43	Other (specify):* Non-allowable cost			42,285	42,285		42,285	(42,285)				43
44	TOTAL Special Cost Centers		58,358	94,852	153,210		153,210	(42,285)	110,925			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,890,781	423,655	1,710,460	4,024,896		4,024,896	(336,758)	3,688,138			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				8
9	Non-Straightline Depreciation	3,802	30		9
10	Interest and Other Investment Income	(71,958)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(345)	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	(681)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,339)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,450)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,340)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(25,069)	43		28
29	Other-Attach Schedule See Pg. 5A	(15,260)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,640)		\$	30

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)	(208,118)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (208,118)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (336,758)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

Shabbona Healthcare Center

ID# 0032169

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs - Part A	\$ (6,350)	43	1
2	X-Rays - Part A	(1,050)	43	2
3	RE Gain/Loss in Partnership	(3,947)	43	3
4	Association Fees	(3,423)	20	4
5	Travel & Seminar	(490)	24	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				25
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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	Total	(15,260)		49

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 Schedule 6A		See Schedule 6B		See 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%	\$ 1,529	\$	1,529	1
2	V	30 Depreciation		Shabbona Building Associates LLC	100.00%	67,784		67,784	2
3	V	32 Interest		Shabbona Building Associates LLC	100.00%	227,940		227,940	3
4	V	32 Amortization of Mortgage Costs		Shabbona Building Associates LLC	100.00%	2,921		2,921	4
5	V	34 Rent-Facility and Grounds	349,859	Shabbona Building Associates LLC	100.00%			(349,859)	5
6	V	43 Other		Shabbona Building Associates LLC	100.00%	3,947		3,947	6
7	V	33 Real Estate Taxes		Shabbona Building Associates LLC	100.00%	50,924		50,924	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 349,859			\$ 355,045	\$ *	5,186	14

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

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:

Beauvais Manor Healthcare and Rehab	St. Louis, MO
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.

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%	73		73	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	712		712	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,571		1,571	18
19	V	17 Administrative	130,125	SW Management Co.	100.00%	18,560		(111,565)	19
20	V	19 Professional Services		SW Management Co.	100.00%	2,344		2,344	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	65		65	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	24,180		24,180	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	8		8	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	721		721	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	341		341	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	9,034		9,034	26
27	V	30 Depreciation		SW Management Co.	100.00%	1,729		1,729	27
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,123		2,123	28
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	632		632	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		\$ 130,125			\$ 62,098	\$ *	(68,027)	39

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

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	\$ 798	S & E Medical Supply Co.	100.00%	\$ 1,774	\$ 976	15
16	V	10 Medical Supplies	2,944	S & E Medical Supply Co.	100.00%	1,405	(1,539)	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		\$ 3,742			\$ 3,179	\$ * (563)	39

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

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%	\$ 6,094	\$ 6,094	15
16	V	32 Interest-Bonds	227,940	SFO Associates	100.00%	77,132	(150,808)	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		\$ 227,940			\$ 83,226	\$ * (144,714)	39

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

Facility Name & ID Number

Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	5.00	Salary	\$ 9,280	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2	5.00	Salary	9,280	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	\$ 18,560		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:

01/01/2008

Ending: 2/31/2008

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	657,492	12	\$ 98	\$ 33,306	\$ 5	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	33,306	73	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	33,306	712	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	33,306	1,571	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	33,306	2,344	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	33,306	65	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	24,180	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	33,306	8	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	33,306	721	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	657,492	12	6,729	33,306	341	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	33,306	9,034	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	33,306	2,123	12	
13	35	Rent - Equipment & Vehicles	Bed Days Available	657,492	12	12,467	33,306	632	13	
14									14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	2	18,560	16
17	17	Administrative	Avg. Hours Worked	50	6	185,600	185,600	0	0	17
18	30	Depreciation	Direct Cost						1,729	18
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 62,098	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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		\$	\$		\$ 1,774	1
2	10	Medical Supplies	Direct Cost					1,405	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				\$	\$		\$ 3,179	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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	\$ 23,300	\$ 1,700,000	\$ 6,094	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	294,915	1,700,000	77,132	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					\$ 318,215	\$	\$ 83,226	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Shabbona Building Assoc	X		Bonds		07/01/94	\$ 1,700,000	\$ 706,154	08/15/14	0.0665	\$ 77,132	1					
2	(Loan Payable-SFO Assoc)											2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 1,700,000	\$ 706,154			\$ 77,132	9					
B. Non-Facility Related*																	
10							Amortization of Loan Costs					2,921	10				
11													11				
12													12				
13													13				
14	TOTAL Non-Facility Related						\$	\$			\$ 2,921	14					
15	TOTALS (line 9+line14)						\$ 1,700,000	\$ 706,154			\$ 80,053	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>48,724.04</u>	\$ <u>48,724.04</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>2,123.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>92,224.38</u>	\$ <u>50,847.04</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? X YES 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>1994</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 2,643,588	\$	39	\$ 67,784	\$ 67,784	\$ 980,123	4
5										5
6	Allocation from Management Co.			21,926		39	626	626	7,928	6
7										7
8										8
	Improvement Type**									
9	Various		1989	2,650	84	20		(84)	2,650	9
10	Various		1990	65,810	1,200	20	3,291	2,091	61,161	10
11	Various		1991	20,535	460	20	725	265	18,723	11
12	Various		1992	5,466		10			4,191	12
13	Various		1993	13,848	393	20	685	292	10,537	13
14	Various		1994	39,334	1,009	20	1,967	958	29,076	14
15	Various		1995	13,479	178	20	674	496	10,128	15
16	Various		1996	11,533	160	20	577	417	8,080	16
17	Various		1997	18,996	487	20	950	463	11,211	17
18	Various		1998	141,664	3,693	20	7,021	3,328	76,447	18
19	Various		1999	2,415	62	20	121	59	1,169	19
20	Air Handler		2000	1,150		10	115	115	997	20
21	Air Handler		2000	1,870		10	187	187	1,605	21
22	Air Handler		2000	1,900		10	190	190	1,615	22
23	Driveway		2001	3,040	78	20	152	74	1,102	23
24	Nurses Call System		2001	2,745		10	275	275	2,060	24
25	Air Handler		2001	1,350		10	135	135	1,046	25
26	Security System		2001	1,507		10	151	151	1,105	26
27	Telephone System		2001	1,928		10	193	193	1,402	27
28	Heating and Cooling System		2002	1,078		20	54	54	355	28
29	Drapes		2003	1,528		10	153	153	879	29
30	Sidewalk Repair		2003	1,250		20	63	63	344	30
31	Wallpaper - North Dining Hall		2004	3,007	109	20	150	41	677	31
32	Air Handlers		2005	6,391	232	20	320	88	1,119	32
33	Windows, fascia and gutters & oversize downspouts		2005	60,785	2,210	20	3,039	829	10,637	33
34	Security control panel		2005	688	25	20	34	9	120	34
35	Patio & Fountain		2006	18,666	1,596	20	933	(663)	2,333	35
36	Fence		2006	2,008	172	20	100	(72)	251	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	\$ 457	37
38	Fire Alarm System	2006	5,392	196	20	270	74	674	38
39	Asphalt	2006	4,200	359	20	210	(149)	525	39
40	Landscaping	2006	99,698	8,524	20	4,985	(3,539)	12,462	40
41	Kitchen Air Conditioners	2007	5,193	1,662	20	260	(1,402)	390	41
42	Roof	2008	21,179	481	20	529	48	529	42
43	Kitchen Remodel	2008	16,036	364	20	401	37	401	43
44									44
45									45
46									46
47									47
48	Allocation from SW management - leasehold improvements	1995	2,339		20	118	118	1,761	48
49	Allocation from SW management - leasehold improvements	1996	409		20	20	20	257	49
50	Allocation from SW management - leasehold improvements	1997	588		20	29	29	411	50
51	Allocation from SW management - leasehold improvements	1998	405		20	20	20	218	51
52	Allocation from SW management - leasehold improvements	1999	1,125		20	56	56	511	52
53	Allocation from SW management - leasehold improvements	2005	2,326		20	116	116	407	53
54	Allocation from SW management - leasehold improvements	2007	1,317		20	66	66	99	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)		\$ 3,274,168	\$ 23,800		\$ 97,925	\$ 74,125	\$ 1,268,172	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	\$ 108,460	\$ 13,328	\$ 11,288	\$ (2,040)	10	\$ 59,951	71
72	Current Year Purchases	2,371	1,245	119	(1,126)	10	119	72
73	Fully Depreciated Assets	343,163				10	343,163	73
74	Allocation from Mgmt Co.	6,923		90	90	10	5,074	74
75	TOTALS	\$ 460,917	\$ 14,573	\$ 11,497	\$ (3,076)		\$ 408,307	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	23,080	78
79	Allocation from Mgmt Co.	2004 Cadillac	2004	2,936		587	587	5	2,642	79
80	TOTALS			\$ 83,754	\$ 3,450	\$ 5,716	\$ 2,266		\$ 75,570	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)	\$ 3,868,839	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,823	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,138	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,315	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,752,049	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: \$ 1,800 Description: Tool Time Rental-\$1800

(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>632</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>632</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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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)	
TOTAL TRAINED	

- (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	\$	1,677	\$ 93,888	\$	1,677	\$ 93,888	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		107	5,189		107	5,189	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,739	90,471		1,739	90,471	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				58,358		58,358	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	3,523	\$ 189,548	\$ 58,358	3,523	\$ 247,906	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: **01/01/2008**

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,277	\$ 4,277	1
2	Cash-Patient Deposits	5,536	5,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,484</u>)	664,276	664,276	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,181	2,181	6
7	Other Prepaid Expenses		608	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	486,964	2,249,438	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,163,234	\$ 2,926,316	10
	B. Long-Term Assets			
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	562,174	630,581	15
16	Equipment, at Historical Cost	360,438	544,671	16
17	Accumulated Depreciation (book methods)	(495,166)	(1,752,049)	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>		64,529	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 427,446	\$ 2,181,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,590,680	\$ 5,107,635	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 64,582	\$ 64,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,968	2,968	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,003	96,003	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,504	11,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,200	50,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	1,931,311	4,513,522	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,156,568	\$ 4,738,779	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		706,154	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 706,154	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,156,568	\$ 5,444,933	46
47	TOTAL EQUITY(page 18, line 24)	\$ (565,888)	\$ (337,298)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,590,680	\$ 5,107,635	48

Shabbona Healthcare Center, Inc.
 Provider #:0032169
 12/31/2008

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interest	1,581	1,581
Employee Loans	16,100	16,100
Employee Payroll Advance	-	-
Due from Shabbona Ret Cnt	469,283	469,283
RE Due to Shabbona Healthcare	-	1,762,474
Total Line 9 - Other Current Assets (specify):	486,964	2,249,438

Other (specify):	Operating	After Consolidation
Investment in SFO	-	19,323
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(42,410)
Total Line 22 - Other Current Liabilities (specify):	-	64,529

Other Current Liabilities (specify):	Operating	After Consolidation
Cash in bank-American National	(114,561)	(114,561)
Reimbursement Due	(8,944)	(8,944)
Insurance Premiums payable	(7,308)	(7,308)
Acc. Retirement (From P/R)	(2,400)	(2,400)
Accrued Expenses	(35,624)	(35,624)
Due/From Shabbona LLC	(1,762,474)	(1,762,474)
RE due to/from - SFO	-	(2,582,211)
Total Line 36 - Other Current Liabilities (specify):	(1,931,311)	(4,513,522)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (366,841)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (366,841)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,045)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (199,047)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (565,888)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,604,733	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,604,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,787	6
7	Oxygen	5,610	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 163,397	8
	C. Other Operating Revenue		
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	2,607	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	18,394	21
22	Laundry	9,485	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 30,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,938	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,938	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Finance Charges	6,497	28
28a	Miscellaneous Income	1,800	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,297	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,825,851	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	930,440	31
32	Health Care	1,667,470	32
33	General Administration	808,336	33
	B. Capital Expense		
34	Ownership	465,440	34
	C. Ancillary Expense		
35	Special Cost Centers	103,250	35
36	Provider Participation Fee	49,960	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,024,896	40
41	Income before Income Taxes (line 30 minus line 40)**	(199,045)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (199,045)	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:

01/01/2008

Ending:

12/31/2008

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	2,080	2,080	\$ 72,891	\$ 35.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,136	2,367	61,309	25.90	3
4	Licensed Practical Nurses	12,895	14,290	328,458	22.99	4
5	CNAs & Orderlies	48,846	52,572	594,482	11.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	27	27	243	9.00	8
9	Activity Director					9
10	Activity Assistants	8,502	9,152	94,876	10.37	10
11	Social Service Workers	2,008	2,192	32,674	14.91	11
12	Dietician					12
13	Food Service Supervisor	2,629	2,781	32,675	11.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,183	15,927	138,319	8.68	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	46,272	22.25	17
18	Housekeepers	21,212	22,407	200,977	8.97	18
19	Laundry	11,029	11,492	91,139	7.93	19
20	Administrator	2,080	2,080	65,256	31.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,305	7,075	131,210	18.55	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)	137,012	146,522	\$ 1,890,781 *	\$ 12.90	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	154	\$ 6,152	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	78	3,752	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	17	830	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	98	4,702	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	347	\$ 15,436		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,820	\$ 179,084	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,035	24,343	L10, C3	52
53	TOTAL (lines 50 - 52)	5,855	\$ 203,427		53

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center, Inc.

Provider #: 0032169

1/1/2008 to 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	84,028
Less : Out of Period and Non-Allowable legal fees	(10,339)
Allocated from Shabbona Building Associates LLC	
Legal	629
Accounting	900
Allocated from SFO Associates	
Accounting	6,094
Allocated from Management Company	
Legal	1,838
Accounting - RSM McGladrey	506
Total (agree to Schedule V, line 19, column 8)	<u>83,656</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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center# 0032169Report Period Beginning: 01/01/2008Ending: 12/31/2008**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. IL Council on Long Term Care-\$7,053
- (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. \$ 20,138 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. \$ 49,960
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. \$ 3,649 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