

Facility Name & ID Number Shabbona Healthcare Center

0032169 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	<u>91</u>	Skilled (SNF)	<u>91</u>	<u>33,215</u>	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	<u>91</u>	TOTALS	<u>91</u>	<u>33,215</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>6</u>	<u>536</u>	<u>2,097</u>	<u>2,639</u>	8	
9	SNF/PED					9	
10	ICF	<u>13,433</u>	<u>8,207</u>		<u>21,640</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>13,439</u>	<u>8,743</u>	<u>2,097</u>	<u>24,279</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.10%

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 04/01/87

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

YES Date 04/01/87 NO

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

YES NO If YES, enter number of beds certified 91 and days of care provided 2,097

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	174,951	7,647	4,217	186,815		186,815		186,815		1
2	Food Purchase		173,691		173,691		173,691	(4,196)	169,495		2
3	Housekeeping	172,171	48,197		220,368		220,368	152	220,520		3
4	Laundry	71,660	10,160		81,820		81,820		81,820		4
5	Heat and Other Utilities			95,712	95,712		95,712	883	96,595		5
6	Maintenance	46,145	43,365	16,361	105,871		105,871	439	106,310		6
7	Other (specify):*										7
8	TOTAL General Services	464,927	283,060	116,290	864,277		864,277	(2,722)	861,555		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,136,155	44,208	88,670	1,269,033		1,269,033	(77)	1,268,956		10
10a	Therapy			223,049	223,049		223,049		223,049		10a
11	Activities	113,584	20,814	3,776	138,174		138,174		138,174		11
12	Social Services	39,582			39,582		39,582		39,582		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,289,321	65,022	315,495	1,669,838		1,669,838	(77)	1,669,761		16
	C. General Administration										
17	Administrative	57,930		125,025	182,955		182,955	(75,905)	107,050		17
18	Directors Fees										18
19	Professional Services			35,655	35,655		35,655	12,306	47,961		19
20	Dues, Fees, Subscriptions & Promotions			11,095	11,095		11,095	(2,379)	8,716		20
21	Clerical & General Office Expenses	170,234		45,433	215,667		215,667	24,579	240,246		21
22	Employee Benefits & Payroll Taxes			254,456	254,456		254,456	4,198	258,654		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,192	2,192		2,192	(361)	1,831		24
25	Other Admin. Staff Transportation			8,877	8,877		8,877	743	9,620		25
26	Insurance-Prop.Liab.Malpractice			47,323	47,323		47,323	303	47,626		26
27	Other (specify):* Mgmt Alloc of Benefit							9,240	9,240		27
28	TOTAL General Administration	228,164		530,056	758,220		758,220	(27,276)	730,944		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,982,412	348,082	961,841	3,292,335		3,292,335	(30,075)	3,262,260		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:

01/01/09

Ending:

12/31/09

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			37,236	37,236		37,236	73,600	110,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,950	76,950		76,950	(26,699)	50,251			32
33	Real Estate Taxes			50,489	50,489		50,489	2,129	52,618			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			1,878	1,878		1,878	634	2,512			35
36	Other (specify):*											36
37	TOTAL Ownership			465,488	465,488		465,488	(249,271)	216,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,758		71,758		71,758		71,758			39
40	Barber and Beauty Shops			1,899	1,899		1,899		1,899			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):* Non-allowable cost			25,515	25,515		25,515	(25,515)				43
44	TOTAL Special Cost Centers		71,758	77,237	148,995		148,995	(25,515)	123,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,982,412	419,840	1,504,566	3,906,818		3,906,818	(304,861)	3,601,957			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	4,266	30		9
10	Interest and Other Investment Income	(3,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(317)	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	(931)	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	(4,897)	43		24
25	Fund Raising, Advertising and Promotional	(13,761)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(645)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	28,486	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 9,201		\$	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)	(314,062)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (314,062)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (304,861)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center

ID# 0032169

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable Dues	\$ (2,882)	20	1
2	Nonallowable Travel and Seminar	(100)	24	2
3	Lab Expense Med A	(4,246)	43	3
4	X Ray Expense Med A	(1,363)	43	4
5	Gain / Loss on Partnership	37,077	43	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
26				26
27				27
28				28
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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	28,486		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 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%	\$ 1,925	\$ 1,925	1
2	V	30 Depreciation		Shabbona Building Associates LLC	100.00%	67,784	67,784	2
3	V	32 Interest	73,950	Shabbona Building Associates LLC	100.00%	201,773	127,823	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	298,935	Shabbona Building Associates LLC	100.00%		(298,935)	5
6	V	43 Other		Shabbona Building Associates LLC	100.00%	645	645	6
7	V	43 Other		Shabbona Building Associates LLC	100.00%	(16,641)	(16,641)	7
8	V	20 Dues & Subscriptions		Shabbona Building Associates LLC	100.00%	151	151	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 372,885			\$ 258,558	\$ * (114,327)	14

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

Shabbona Healthcare Center, Inc.
0032169
12/31/2009

VII Related Parties - Page 6

Schedule 6A

Share Number	Shareholder Name	Beginning Shares	Ownership Percentage
1	Albert Milstein	50	50
2	Sheldon Wolfe	50	50

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:

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

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
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%	\$ 9	\$ 9
16	V	3 Housekeeping		SW Management Co.	100.00%	152	152
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	883	883
18	V	6 Maintenance		SW Management Co.	100.00%	439	439
19	V	17 Administrative	95,025	SW Management Co.	100.00%	19,120	(75,905)
20	V	19 Professional Services		SW Management Co.	100.00%	2,494	2,494
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	82	82
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	24,513	24,513
23	V	24 Travel and Seminar		SW Management Co.	100.00%	9	9
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	743	743
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	303	303
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	9,240	9,240
27	V	30 Depreciation		SW Management Co.	100.00%	1,550	1,550
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,129	2,129
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	634	634
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 95,025			\$ 62,300	\$ * (32,725)

* 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	\$ 397	S & E Medical Supply Co.	100.00%	\$ 390	\$	(7)	15
16	V	10 Medical Supplies	285	S & E Medical Supply Co.	100.00%	208		(77)	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		\$ 682			\$ 598	\$ *	(84)	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	0.00%	\$ 7,887	\$ 7,887
16	V	21 Clerical & General Office		SFO Associates	0.00%	66	66
17	V	32 Interest-Bonds	201,773	SFO Associates	0.00%	47,330	(154,443)
18	V	43 Other		SFO Associates	0.00%	(20,436)	(20,436)
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		\$ 201,773			\$ 34,847	\$ * (166,926)

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

Facility Name & ID Number

Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 9,560	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2	5.00	Salary	9,560	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	\$ 19,120		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:

01/01/09

Ending: 12/31/09

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 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

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	657,730	11	\$ 177	\$ 33,215	\$ 9	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	33,215	152	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	33,215	883	3	
4	6	Maintenance	Bed Days Available	657,730	11	8,697	33,215	439	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	33,215	2,494	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,730	11	1,616	33,215	82	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	33,215	24,513	7
8	24	Travel and Seminar	Bed Days Available	657,730	11	186	33,215	9	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	33,215	743	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	657,730	11	5,991	33,215	303	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	33,215	9,240	11	
12	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	33,215	2,129	12	
13	35	Rent - Equipment & Vehicles	Bed Days Available	657,730	11	12,559	33,215	634	13	
14									14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	382,400	2	19,120	16	
17	17	Administrative	Avg. Hours Worked	50	11	191,200	0	0	17	
18									18	
19	30	Depreciation	Direct Cost					1,550	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 432,056	\$ 62,300	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 390	1
2	10	Medical Supplies	Direct Cost					208	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				\$	\$		\$ 598	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 30,158	\$ 1,700,000	\$ 7,887	1
2	21	Clerical & General Office	Note Receivable	6,500,000	3	253	1,700,000	66	2
3	32	Interest-Bonds	Note Receivable	6,500,000	3	180,969	1,700,000	47,330	3
4	43	Other	Note Receivable	6,500,000	3	(78,136)	1,700,000	(20,436)	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					\$ 133,244	\$	\$ 34,847	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>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:

01/01/09

Ending:

12/31/09

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	\$ 1,047,908	4
5											5
6	Allocation from Management Co.				21,859		39	625	625	9,152	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	64,455	10
11	Various		1991		20,535	460	20	725	265	19,448	11
12	Various		1992		5,466		10			4,191	12
13	Various		1993		13,848	393	20	685	292	11,221	13
14	Various		1994		39,334	1,009	20	1,967	958	31,042	14
15	Various		1995		13,479	178	20	674	496	10,802	15
16	Various		1996		11,533	160	20	577	417	8,656	16
17	Various		1997		18,996	487	20	950	463	12,161	17
18	Various		1998		141,664	3,693	20	7,021	3,328	83,469	18
19	Various		1999		2,415	62	20	121	59	1,290	19
20	Air Handler		2000		1,150		10	115	115	1,112	20
21	Air Handler		2000		1,870		10	187	187	1,792	21
22	Air Handler		2000		1,900		10	190	190	1,805	22
23	Driveway		2001		3,040	78	20	152	74	1,254	23
24	Nurses Call System		2001		2,745		10	275	275	2,334	24
25	Air Handler		2001		1,350		10	135	135	1,181	25
26	Security System		2001		1,507		10	151	151	1,255	26
27	Telephone System		2001		1,928		10	193	193	1,595	27
28	Heating and Cooling System		2002		1,078		20	54	54	408	28
29	Drapes		2003		1,528		10	153	153	1,032	29
30	Sidewalk Repair		2003		1,250		20	63	63	406	30
31	Wallpaper - North Dining Hall		2004		3,007	109	20	150	41	827	31
32	Air Handlers		2005		6,391	232	20	320	88	1,438	32
33	Windows, fascia and gutters & oversize downspouts		2005		60,785	2,210	20	3,039	829	13,677	33
34	Security control panel		2005		688	25	20	34	9	154	34
35	Patio & Fountain		2006		18,666	1,437	20	933	(504)	3,267	35
36	Fence		2006		2,008	155	20	100	(55)	351	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	\$ 639	37
38	Fire Alarm System	2006	5,392	196	20	270	74	944	38
39	Asphalt	2006	4,200	323	20	210	(113)	735	39
40	Landscaping	2006	99,698	7,677	20	4,985	(2,692)	17,447	40
41	Kitchen Air Conditioners	2007	5,193	997	20	260	(737)	649	41
42	Roof	2008	21,179	770	20	1,059	289	1,588	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036	583	20	802	219	1,203	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800	201	20	195	(6)	195	45
46									46
47									47
48	Allocation from SW management - leasehold improvements	1995	2,332		20	117	117	1,873	48
49	Allocation from SW management - leasehold improvements	1996	407		20	20	20	276	49
50	Allocation from SW management - leasehold improvements	1997	586		20	29	29	439	50
51	Allocation from SW management - leasehold improvements	1998	404		20	20	20	237	51
52	Allocation from SW management - leasehold improvements	1999	1,121		20	56	56	565	52
53	Allocation from SW management - leasehold improvements	2005	2,319		20	116	116	522	53
54	Allocation from SW management - leasehold improvements	2007	1,313		20	66	66	164	54
55	Allocation from SW management - leasehold improvements	2009	2,741		20	69	69	69	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)		\$ 3,284,615	\$ 22,785		\$ 99,117	\$ 76,332	\$ 1,367,877	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Shabbona Healthcare Center

0032169

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 95,461	\$ 8,412	\$ 8,439	\$ 27	10	\$ 53,141	71
72	Current Year Purchases	5,662	3,398	283	(3,115)	10	283	72
73	Fully Depreciated Assets	358,533				10	358,533	73
74	Allocated from Management Co.	6,901		140	140	10	5,198	74
75	TOTALS	\$ 466,557	\$ 11,810	\$ 8,862	\$ (2,948)		\$ 417,155	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	866	2,564	1,698	5	25,644	78
79	Allocated from Management	2004 Cadillac	2004	2,927		293	293	5	2,927	79
80	TOTALS			\$ 83,745	\$ 2,641	\$ 2,857	\$ 216		\$ 78,419	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)	\$ 3,884,917	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,836	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,600	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,863,452	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:				\$ <u>N/A</u>			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: \$ 1,878 Description: Tools-\$1878

(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>Allocated from Management Co.</u>		\$	\$ <u>634</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>634</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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$	1,007	\$ 112,742	\$	1,007	\$ 112,742	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		119	2,844		119	2,844	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		982	102,175		982	102,175	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 prescripts				71,758		71,758	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			\$	2,108	\$ 217,761	\$ 71,758	2,108	\$ 289,519	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: **01/01/09**

Ending: **12/31/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 32,478	\$ 32,478	1
2	Cash-Patient Deposits	6,653	6,653	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>8,045</u>)	581,575	581,575	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,068	2,068	6
7	Other Prepaid Expenses		608	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	590,691	2,598,715	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,213,465	\$ 3,222,097	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		2,665,445	14
15	Leasehold Improvements, at Historical Cost	569,974	619,170	15
16	Equipment, at Historical Cost	366,100	550,302	16
17	Accumulated Depreciation (book methods)	(532,402)	(1,863,452)	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 (spe <u>See Schedule 17A</u>)		78,247	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 403,672	\$ 2,099,712	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,617,137	\$ 5,321,809	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 34,727	\$ 34,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,992	2,992	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,441	31,441	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,021	6,021	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,100	51,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	2,063,663	4,827,647	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,189,944	\$ 4,953,928	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		601,539	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)	\$	\$ 601,539	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,189,944	\$ 5,555,467	46
47	TOTAL EQUITY(page 18, line 24)	\$ (572,807)	\$ (233,658)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,617,137	\$ 5,321,809	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Shabbona Healthcare Center, Inc.
 Provider #:0032169
 12/31/2009

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interest	10,108	10,108
Employee Loans	15,800	15,800
Due from Shabbona Ret Cnt	564,783	564,783
RE Due from Shabbona Healthcare	-	2,008,024
Total Line 9 - Other Current Assets (specify):	590,691	2,598,715

Other (specify):	Operating	After Consolidation
Investment in SFO	-	35,962
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(45,331)
Total Line 22 - Other Current Liabilities (specify):	-	78,247

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums payable	(562)	(562)
Acc. Retirement (From P/R)	(550)	(550)
Accrued Expenses	(49,577)	(49,577)
Short Term Loan Exchange	(4,950)	(4,950)
Due To/From Shabbona LLC	(2,008,024)	(2,008,024)
RE due to/from - SFO	-	(2,763,984)
Total Line 36 - Other Current Liabilities (specify):	(2,063,663)	(4,827,647)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (565,888)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (565,888)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,917)	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)	\$ (6,919)	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)	\$ (572,807)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center# 0032169Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 3,641,091	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,641,091	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	191,316	6
7	Oxygen	3,683	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 194,999	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	2,033	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	13,721	21
22	Laundry	8,336	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,090	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	36,285	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,285	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Finance Charges & Transportation	1,576	28
28a	Medicaid Income Adjustment	1,860	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,436	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,899,901	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	864,277	31
32	Health Care	1,669,838	32
33	General Administration	758,220	33
B. Capital Expense			
34	Ownership	465,488	34
C. Ancillary Expense			
35	Special Cost Centers	99,172	35
36	Provider Participation Fee	49,823	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,906,818	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,917)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,917)	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:

01/01/09

Ending:

12/31/09

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	2,128	2,160	\$ 61,437	\$ 28.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,633	5,201	139,970	26.91	3
4	Licensed Practical Nurses	14,229	16,078	364,006	22.64	4
5	CNAs & Orderlies	51,603	55,822	570,742	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,595	11,545	113,584	9.84	10
11	Social Service Workers	2,348	2,572	39,582	15.39	11
12	Dietician					12
13	Food Service Supervisor	2,247	2,397	27,371	11.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,901	17,747	147,580	8.32	15
16	Dishwashers					16
17	Maintenance Workers	2,160	2,160	46,145	21.36	17
18	Housekeepers	18,525	19,781	172,171	8.70	18
19	Laundry	8,743	9,211	71,660	7.78	19
20	Administrator	1,920	1,920	57,930	30.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,297	9,087	170,234	18.73	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)	144,329	155,681	\$ 1,982,412 *	\$ 12.73	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	105	\$ 4,217	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	110	5,276	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	110	5,288	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	79	3,776	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	404	\$ 18,557		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	2,085	83,394	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,085	\$ 83,394		53

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center, Inc.

Provider #: 0032169

1/1/2009 to 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	35,655
Allocated from Shabbona Building Associates LLC	
Accounting	1,925
Allocated from SFO Associates	
Accounting	7,887
Allocated from Management Company	
Legal	1,579
Accounting - RSM McGladrey	915
Total (agree to Schedule V, line 19, column 8)	<u>47,961</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								
FY2006					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
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# 0032169

Report Period Beginning:

01/01/09

Ending:

12/31/09**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 Long Term Care-\$4,216
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,515 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.
- (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. \$ 4,198 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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT