FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0032169

Facility Name: Shabbona Healthcare Center

Address: 409 West Comanche Avenue (Number) Shabbona (City) 60550 (Zip Code)

County: DeKalb

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

HFS ID Number:

Date of Initial License for Current Owners: 04/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	119	747	1,338	2,204	8
9	SNF/PED					9
10	ICF	15,382	7,754	20	23,156	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,501	8,501	1,358	25,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.35%

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 [X] 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 [X]

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 [X] Date 04/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 91 and days of care provided 1,338

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,952	6,944	6,308	222,204		222,204		222,204			1
2	Food Purchase		216,729		216,729		216,729	(4,489)	212,240			2
3	Housekeeping	132,791	56,960		189,751		189,751	50	189,801			3
4	Laundry	78,506	16,125		94,631		94,631		94,631			4
5	Heat and Other Utilities			92,250	92,250		92,250	761	93,011			5
6	Maintenance	49,829	57,241	15,702	122,772		122,772	325	123,097			6
7	Other (specify):*											7
8	**TOTAL General Services**	470,078	353,999	114,260	938,337		938,337	(3,353)	934,984			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	1,184,793	47,858	100,263	1,332,914		1,332,914	3	1,332,917			10
10a	Therapy			213,766	213,766		213,766		213,766			10a
11	Activities	132,458	24,758	5,200	162,416		162,416		162,416			11
12	Social Services	37,992			37,992		37,992		37,992			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,355,243	72,616	323,229	1,751,088		1,751,088	3	1,751,091			16
	C. General Administration											
17	Administrative	59,973		121,200	181,173		181,173	(66,438)	114,735			17
18	Directors Fees											18
19	Professional Services			32,666	32,666		32,666	14,016	46,682			19
20	Dues, Fees, Subscriptions & Promotions			14,512	14,512		14,512	(3,026)	11,486			20
21	Clerical & General Office Expenses	179,074		52,058	231,132		231,132	26,846	257,978			21
22	Employee Benefits & Payroll Taxes			322,124	322,124		322,124	4,570	326,694			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,151	5,151		5,151	(898)	4,253			24
25	Other Admin. Staff Transportation			11,961	11,961		11,961	590	12,551			25
26	Insurance-Prop.Liab.Malpractice			11,217	11,217		11,217	275	11,492			26
27	Other (specify):* Mgmt Alloc of Benefit							7,853	7,853			27
28	**TOTAL General Administration**	239,047		570,889	809,936		809,936	(16,212)	793,724			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,064,368	426,615	1,008,378	3,499,361		3,499,361	(19,562)	3,479,799			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: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,543	72,543		72,543	34,805	107,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,270	83,270		83,270	(45,408)	37,862			32
33	Real Estate Taxes			49,612	49,612		49,612	1,634	51,246			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles							557	557			35
36	Other (specify):*											36
37	TOTAL Ownership			504,360	504,360		504,360	(307,347)	197,013			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,997		51,997		51,997		51,997			39
40	Barber and Beauty Shops			2,009	2,009		2,009		2,009			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 Cos			24,110	24,110		24,110	(24,110)				43
44	TOTAL Special Cost Centers		51,997	75,942	127,939		127,939	(24,110)	103,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,064,368	478,612	1,588,680	4,131,660		4,131,660	(351,019)	3,780,641			45

***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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(34,496)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(338)	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	(5,000)	43		18
19	Entertainment				19
20	Contributions	(946)	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	(7,457)	43		24
25	Fund Raising, Advertising and Promotional	(6,057)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(984)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	855	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,423)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(296,596)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (296,596)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (351,019)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center

ID# 0032169

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (925)	24	1
2	Lab Expense Med A	(2,594)	43	2
3	X Ray Expense Med A	(347)	43	3
4	Bank Services Charges	(1,371)	43	4
5	RE Gain/Loss	9,423	43	5
6	Association fees	(3,331)	20	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
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	855		49

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Shabbona Building Associates LLC	100.00%	$ 3,600	$ 3,600	1
2	V	20	Dues & Subscriptions		Shabbona Building Associates LLC	100.00%	251	251	2
3	V	30	Depreciation		Shabbona Building Associates LLC	100.00%	67,784	67,784	3
4	V	32	Interest	83,270	Shabbona Building Associates LLC	100.00%	150,266	66,996	4
5	V	32	Amortization of Mortgage Costs		Shabbona Building Associates LLC	100.00%	2,921	2,921	5
6	V	34	Rent-Facility and Grounds	298,935	Shabbona Building Associates LLC	100.00%		(298,935)	6
7	V	43	Other		Shabbona Building Associates LLC	100.00%	984	984	7
8	V	43	Other	9,423	Shabbona Building Associates LLC	100.00%		(9,423)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 391,628			$ 225,806	$ * (165,822)	14

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

Shabbona Healthcare Center, Inc.
0032169
12/31/2010

VII Related Parties - Page 6 Schedule 6A

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

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center, Inc.
0032169
12/31/2010

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:	
Rosewood Health and Rehab Center	Independence, MO
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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Management Co.	100.00%	$ 88	$ 88	15
16	V	3	Housekeeping		SW Management Co.	100.00%	50	50	16
17	V	5	Heat and Other Utilities		SW Management Co.	100.00%	761	761	17
18	V	6	Maintenance		SW Management Co.	100.00%	325	325	18
19	V	17	Administrative	85,200	SW Management Co.	100.00%	18,762	(66,438)	19
20	V	19	Professional Services		SW Management Co.	100.00%	1,086	1,086	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	54	54	21
22	V	21	Clerical & General Office Expense		SW Management Co.	100.00%	26,846	26,846	22
23	V	24	Travel and Seminar		SW Management Co.	100.00%	27	27	23
24	V	25	Other Admin. Staff Transport		SW Management Co.	100.00%	590	590	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	275	275	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.	100.00%	7,853	7,853	26
27	V	30	Depreciation		SW Management Co.	100.00%	1,517	1,517	27
28	V	32	Interest		SW Management Co.	100.00%	35	35	28
29	V	33	Real Estate Taxes		SW Management Co.	100.00%	1,634	1,634	29
30	V	34	Rent - Facility & Grounds		SW Management Co.	100.00%	0		30
31	V	35	Rent - Equipment & Vehicles		SW Management Co.	100.00%	557	557	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 85,200			$ 60,460	$ * (24,740)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 45	S & E Medical Supply Co.	100.00%	$ 38	$ (7)	15
16	V	10	Medical Supplies		S & E Medical Supply Co.	100.00%	3	3	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			$ 45			$ 41	$ * (4)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	SFO Associates	0.00%	$ 9,330	$ 9,330	15
16	V	32	Interest-Bonds	150,266	SFO Associates	0.00%	34,906	(115,360)	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			$ 150,266			$ 44,236	$ * (106,030)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	50.00	See Schedule 7A	2	4.76	Salary	$ 9,381	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2	4.76	Salary	9,381	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	$ 18,762		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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	742,930	12	$ 1,959	$	33,215	$ 88	1
2	3	Housekeeping	Bed Days Available	742,930	12	1,125		33,215	50	2
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016		33,215	761	3
4	6	Maintenance	Bed Days Available	742,930	12	7,264		33,215	325	4
5	19	Professional Services	Bed Days Available	742,930	12	24,293		33,215	1,086	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	742,930	12	1,198		33,215	54	6
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	33,215	26,846	7
8	24	Travel and Seminar	Bed Days Available	742,930	12	594		33,215	27	8
9	25	Other Admin. Staff Transport	Bed Days Available	742,930	12	13,194		33,215	590	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	742,930	12	6,148		33,215	275	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644		33,215	7,853	11
12	32	Interest	Bed Days Available	742,930	12	778		33,215	35	12
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555		33,215	1,634	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	742,930	12	12,454		33,215	557	14
15										15
16	17	Administrative	Avg. Hours Worked	84	12	394,000	394,000	4	18,762	16
17	17	Administrative	Avg. Hours Worked	50	6	197,000	197,000		0	17
18										18
19	30	Depreciation	Direct Cost	33,940					1,517	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,489,690	$ 1,100,094		$ 60,460	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 38	1
2	10	Medical Supplies	Direct Cost						3	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					$	$		$ 41	25

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	$ 35,675	$	1,700,000	$ 9,330	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	133,465		1,700,000	34,906	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					$ 169,140	$		$ 44,236	25

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Shabbona Building Assoc.	X		Bonds	Interest Only	7/1/94	$ 1,700,000	$ 496,923	8/15/14	Variable	$ 34,906	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	$ 496,923			$ 34,906	9
	B. Non-Facility Related*											
10								Amortization of loan costs			2,921	10
11								Allocation from Management Co.			35	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,956	14
15	TOTALS (line 9+line14)						$ 1,700,000	$ 496,923			$ 37,862	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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.)**

Facility Name & ID Number Shabbona Healthcare Center **#** 0032169 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 51,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 49,612	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,488)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	**Mgmt. Alloc.**	$ 222	5
	Allocated from Management Co.	1,412	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 51,246	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	44,758	8
2006	46,340	9
2007	48,724	10
2008	49,589	11
2009	49,612	12

RE Tax Accrual = 49,612 X 1.03 = 51,100. Use 51,100

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 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) 983-2304

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long Term Care Property	$ 49,612.04	$ 49,612.04
2.	10-28-412-049-0000	SW Management Allocation	$ 33,634.00	$ 1,412.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,246.04	$ 51,024.04

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1994	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$	39	$ 67,784	$ 67,784	$ 1,115,688	4
5											5
6	Allocation from Management Co.				19,351		39	553	553	8,655	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	1,349	149	65,804	10
11	Various			1991	20,536	460	20	769	309	20,217	11
12	Various			1992	5,466		10			4,191	12
13	Various			1993	13,848	393	20	685	292	11,906	13
14	Various			1994	39,334	1,009	20	1,967	958	33,009	14
15	Various			1995	13,479	178	20	674	496	11,476	15
16	Various			1996	11,533	160	20	577	417	9,233	16
17	Various			1997	18,996	487	20	950	463	13,111	17
18	Various			1998	141,664	3,693	20	7,021	3,328	90,490	18
19	Various			1999	2,415	62	20	121	59	1,411	19
20	Air Handler			2000	1,150		10	38	38	1,150	20
21	Air Handler			2000	1,870		10	78	78	1,870	21
22	Air Handler			2000	1,900		10	78	78	1,883	22
23	Driveway			2001	3,040	78	20	152	74	1,406	23
24	Nurses Call System			2001	2,745		10	275	275	2,609	24
25	Air Handler			2001	1,350		10	135	135	1,316	25
26	Security System			2001	1,507		10	151	151	1,406	26
27	Telephone System			2001	1,928		10	193	193	1,788	27
28	Heating and Cooling System			2002	1,078		20	54	54	462	28
29	Drapes			2003	1,528		10	153	153	1,185	29
30	Sidewalk Repair			2003	1,250		20	63	63	469	30
31	Wallpaper - North Dining Hall			2004	3,007	109	20	150	41	977	31
32	Air Handlers			2005	6,391	232	20	320	88	1,758	32
33	Windows, fascia and gutters & oversize downspouts			2005	60,785	2,210	20	3,039	829	16,716	33
34	Security control panel			2005	688	25	20	34	9	188	34
35	Patio & Fountain			2006	18,666	1,294	20	933	(361)	4,200	35
36	Fence			2006	2,008	139	20	100	(39)	451	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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	3 Glass Doors	2006	$ 1,826	$ 66	10	$ 183	$ 117	$ 822	37
38	Fire Alarm System	2006	5,392	196	20	270	74	1,214	38
39	Asphalt	2006	4,200	291	20	210	(81)	945	39
40	Landscaping	2006	99,698	6,909	20	4,985	(1,924)	22,432	40
41	Kitchen Air Conditioners	2007	5,193	598	20	260	(338)	909	41
42	Roof	2008	21,179	770	20	1,059	289	2,647	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036	583	20	802	219	2,005	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800	284	20	390	106	585	45
46									46
47	Repave Parking Lots	2010	6,798	3,569	20	170	(3,399)	170	47
48	Sealcoat Parking Lots	2010	2,610	1,371	20	65	(1,306)	65	48
49	Retaining Walls & Walkways	2010	16,190	8,500	20	380	(8,120)	380	49
50	Replanting Trees	2010	10,119	10,119	20	253	(9,866)	253	50
51									51
52									52
53									53
54									54
55									55
56	Allocation from SW management - leasehold improvements	1995	2,166		20	108	108	1,842	56
57	Allocation from SW management - leasehold improvements	1996	361		20	18	18	263	57
58	Allocation from SW management - leasehold improvements	1997	418		20	21	21	334	58
59	Allocation from SW management - leasehold improvements	1998	357		20	18	18	228	59
60	Allocation from SW management - leasehold improvements	1999	993		20	50	50	550	60
61	Allocation from SW management - leasehold improvements	2005	2,053		20	103	103	565	61
62	Allocation from SW management - leasehold improvements	2007	1,162		20	58	58	203	62
63	Allocation from SW management - leasehold improvements	2009	2,427		20	121	121	182	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,316,538	$ 45,069		$ 97,920	$ 52,851	$ 1,464,269	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: 01/01/10 Ending: 12/31/10

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	$ 75,053	$ 6,569	$ 7,505	$ 936	10	$ 34,859	71
72	Current Year Purchases	29,089	17,455	1,455	(16,000)	10	1,455	72
73	Fully Depreciated Assets	384,603				10	384,603	73
74	Allocated from Management Co.	6,110		124	124		4,726	74
75	TOTALS	$ 494,855	$ 24,024	$ 9,084	$ (14,940)		$ 425,643	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		(1,675)	5	25,644	78
79	Allocated from Management	2010 Infiniti	2010	3,438		344	344		344	79
80	TOTALS			$ 84,256	$ 3,450	$ 344	$ (3,106)		$ 75,836	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)	$ 3,945,649	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,543	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,348	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,805	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,965,748	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.

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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:				$ N/A			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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
(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	Allocated from management		$	$ 557	17
18					18
19					19
20					20
21	TOTAL		$	$ 557	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	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	$	923	$ 103,324	$	923	$ 103,324	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		295	7,078		295	7,078	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		971	101,012		971	101,012	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				51,997		51,997	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			$	2,189	$ 211,414	$ 51,997	2,189	$ 263,411	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

STATE OF ILLINOIS

Facility Name & ID Number Shabbona Healthcare Center **#** 0032169 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 **(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	$ 2,635	$ 2,635	1
2	Cash-Patient Deposits	13,133	13,133	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	653,190	653,190	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,250	1,250	6
7	Other Prepaid Expenses		281	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	757,057	2,995,837	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,427,265	$ 3,666,326	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		2,662,938	14
15	Leasehold Improvements, at Historical Cost	605,690	653,600	15
16	Equipment, at Historical Cost	395,189	579,111	16
17	Accumulated Depreciation (book methods)	(604,945)	(1,965,748)	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 See Schedule 17A		84,749	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 395,934	$ 2,064,650	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,823,199	$ 5,730,976	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,277	$ 51,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,296	21,296	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,544	32,544	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,261	6,261	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	See Schedule 17A	2,411,829	5,283,752	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,574,307	$ 5,446,230	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		496,923	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)**	$	$ 496,923	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,574,307	$ 5,943,153	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (751,108)	$ (212,177)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,823,199	$ 5,730,976	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Shabbona Healthcare Center, Inc.
Provider #:0032169
12/31/2010

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State	(100)	(99)
Due from State-Interest	8,578	8,578
Employee Loans	16,200	16,200
Employee Payroll Advance	588	588
Short Term Loan Exchange	67,708	67,708
Due from Shabbona Ret Cnt	664,083	664,083
RE Due from Shabbona Healthcare	-	2,238,780
Total Line 9 - Other Current Assets (specify):	**757,057**	**2,995,838**

Other (specify):	Operating	After Consolidation
Investment in SFO	-	45,385
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(48,252)
Total Line 22 - Other Current Liabilities (specify):	**-**	**84,749**

Other Current Liabilities (specify):	Operating	After Consolidation
Reimbursement Due	70,324	70,324
Insurance Premiums payable	328	328
Acc. Retirement (From P/R)	-	-
Accrued Expenses	108,397	108,397
Accrued Management Fees	(6,000)	(6,000)
Short Term Loan Exchange	-	-
Due To/From Shabbona LLC	2,238,780	2,238,780
RE due to/from - SFO	-	2,871,923
Total Line 36 - Other Current Liabilities (specify):	**2,411,829**	**5,283,752**

See Accountants' Compilation Report

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (572,807)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (572,807)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(178,300)	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**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (178,301)	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)**	$ (751,108)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,705,719	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,705,719	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	210,590	6
7	Oxygen	1,028	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 211,618	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	1,623	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	7,410	21
22	Laundry	2,321	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,354	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,669	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,669	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,953,360	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	938,337	31
32	Health Care	1,751,088	32
33	General Administration	809,936	33
	B. Capital Expense		
34	Ownership	504,360	34
	C. Ancillary Expense		
35	Special Cost Centers	78,116	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)***	$ 4,131,660	40
41	**Income before Income Taxes (line 30 minus line 40)****	(178,300)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (178,300)	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: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	1,920	$ 61,670	$ 32.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,220	7,929	221,685	27.96	3
4	Licensed Practical Nurses	13,017	14,573	382,784	26.27	4
5	CNAs & Orderlies	44,073	47,120	518,654	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,986	12,019	132,458	11.02	10
11	Social Service Workers	2,042	2,181	37,992	17.42	11
12	Dietician					12
13	Food Service Supervisor	1,959	2,043	35,257	17.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,907	17,878	173,695	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,085	2,109	49,829	23.63	17
18	Housekeepers	12,799	13,696	132,791	9.70	18
19	Laundry	8,245	8,587	78,506	9.14	19
20	Administrator	1,888	1,920	59,973	31.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,974	8,676	179,074	20.64	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)	131,107	140,651	$ 2,064,368 *	$ 14.68	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	158	$ 6,308	L1, C3	35
36	Medical Director	77	4,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	16	761	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	49	2,352	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	108	5,200	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	408	$ 18,621		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,085	99,502	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,085	$ 99,502		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eileen Gates	Administrator	0	$ 243
Sherri Whitmer	Administrator	0	59,730
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,973

B. Administrative - Other

Description	Amount
Home Office	$ 61,200
Management Fees	60,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 121,200

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/E Consultant	$ 1,140
McGladrey & Pullen LLP	Accounting	22,328
Honkamp & Kruerger Co	Accounting	2,311
Margel S. Peddicord, CPA	Accounting	1,222
Stone Mcguire & Siegel	Legal	5,665
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 32,666

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,161
Unemployment Compensation Insurance	27,480
FICA Taxes	157,924
Employee Health Insurance	57,385
Employee Meals	4,570
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	1,760
Holiday Expense	1,450
Employee Life Insurance	(1,036)
TOTAL (agree to Schedule V, line 22, col.8)	$ 326,694

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,119
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 151)	1,810
Patient Background Checks	
Illinois Council on Long Term Care	7,917
Miscellaneous Dues & Permits	1,024
Miscellaneous Inspections & Licenses	642
Allocated from Management Co.	305
Less : Nonallowable Dues	(3,331)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,486

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,226
Allocated from Management Co.	27
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,253

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center, Inc.
Provider #: 0032169
1/1/2010 to 12/31/2010 Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	32,666
Allocated from Shabbona Building Associates LLC	
Accounting	600
Allocated from SFO Associates	
Accounting	9,330
Allocated from Management Company	
Legal	3,481
Accounting - RSM McGladrey	605
gree to Schedule V, line 19, column 8)	46,682

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/10 Ending: 12/31/10

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 01/01/10 Ending: 12/31/10

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-$7,917**

(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. $ **13,536** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **49,823**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,570** Has any meal income been offset against related costs? **No** 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.