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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0032169

Facility Name: Shabbona Healthcare Center, Inc.

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 01/01/11 to 12/31/11 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' PREPARATION 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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	146	1,042	1,767	2,955	8
9	SNF/PED					9
10	ICF	14,007	8,627		22,634	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,153	9,669	1,767	25,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.04%

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 1,767

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	244,297	9,835	4,330	258,462		258,462		258,462			1
2	Food Purchase		233,934		233,934		233,934	(5,485)	228,449			2
3	Housekeeping	152,489	70,374		222,863		222,863	68	222,931			3
4	Laundry	53,671	21,510		75,181		75,181		75,181			4
5	Heat and Other Utilities			83,307	83,307		83,307	868	84,175			5
6	Maintenance	49,658	51,665	19,012	120,335		120,335	340	120,675			6
7	Other (specify):*											7
8	**TOTAL General Services**	500,115	387,318	106,649	994,082		994,082	(4,209)	989,873			8
	B. Health Care and Programs											
9	Medical Director			11,500	11,500		11,500		11,500			9
10	Nursing and Medical Records	1,244,644	55,065	249,994	1,549,703		1,549,703	10	1,549,713			10
10a	Therapy			220,188	220,188		220,188		220,188			10a
11	Activities	106,212	25,768	7,279	139,259		139,259		139,259			11
12	Social Services	35,940			35,940		35,940		35,940			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,386,796	80,833	488,961	1,956,590		1,956,590	10	1,956,600			16
	C. General Administration											
17	Administrative	65,673		60,000	125,673		125,673	(2,155)	123,518			17
18	Directors Fees											18
19	Professional Services			32,999	32,999		32,999	9,023	42,022			19
20	Dues, Fees, Subscriptions & Promotions			16,015	16,015		16,015	(1,737)	14,278			20
21	Clerical & General Office Expenses	198,443		53,967	252,410		252,410	35,606	288,016			21
22	Employee Benefits & Payroll Taxes			349,719	349,719		349,719	5,581	355,300			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,842	7,842		7,842	(1,269)	6,573			24
25	Other Admin. Staff Transportation			15,875	15,875		15,875	1,353	17,228			25
26	Insurance-Prop.Liab.Malpractice			5,166	5,166		5,166	246	5,412			26
27	Other (specify):* Mgmt Alloc of Benefit							10,765	10,765			27
28	**TOTAL General Administration**	264,116		541,583	805,699		805,699	57,413	863,112			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,151,027	468,151	1,137,193	3,756,371		3,756,371	53,214	3,809,585			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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, Inc. #0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			77,881	77,881		77,881	33,969	111,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,903	42,903		42,903	(7,893)	35,010			32
33	Real Estate Taxes			24,967	24,967		24,967	4,231	29,198			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			1,034	1,034		1,034	(363)	671			35
36	Other (specify):*											36
37	**TOTAL Ownership**			445,720	445,720		445,720	(268,991)	176,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,408	1,844	56,252		56,252		56,252			39
40	Barber and Beauty Shops			2,539	2,539		2,539		2,539			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):* **Non-Allow Costs**			23,010	23,010		23,010	(23,010)				43
44	**TOTAL Special Cost Centers**		54,408	77,216	131,624		131,624	(23,010)	108,614			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,151,027	522,559	1,660,129	4,333,715		4,333,715	(238,787)	4,094,928			45

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(36,060)	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	(455)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,471)	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	(1,088)	43		24
25	Fund Raising, Advertising and Promotional	(8,058)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,881)	43		28
29	Other-Attach Schedule See Pg 5A	4,861	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,152)		$	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)	(193,635)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (193,635)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,787)		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.		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

Shabbona Healthcare Center, Inc.

ID# 0032169

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (1,283)	24	1
2	Lab Expense Med A	(4,526)	43	2
3	X Ray Expense Med A	(1,811)	43	3
4	Bank Services Charges	(2,720)	43	4
5	Association fees	(2,236)	20	5
6	RE Gain/Loss	17,437	43	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
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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**	4,861		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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%	$ 2,635	$ 2,635	1
2	V	20	Dues & Subscriptions		Shabbona Building Associates LLC	100.00%	425	425	2
3	V	30	Depreciation		Shabbona Building Associates LLC	100.00%	67,784	67,784	3
4	V	32	Interest	39,100	Shabbona Building Associates LLC	100.00%	80,553	41,453	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	17,437	Shabbona Building Associates LLC	100.00%		(17,437)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 355,472			$ 154,318	$ * (201,154)	14

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Albert Milstein	50%	Cahokia Nursing and Rehab	Cahokia	Shabbona Supportive I	Shabbona	Supportive Living F	1
2	Sheldon Wolfe	50%	Caseyville Nursing and Rehab	Caseyville	S.W. Management Co.	Skokie	Bookkeeping/Manag	2
3			Shabbona Healthcare Center	Shabbona	S&E Medical Supply C	Skokie	Medical Supplies	3
4					*SFO Associates	Skokie	Finance Company	4
5								5
6					* This entity only relates to Shabbona Healthcare Center,			6
7			Rosewood Health and Rehab Center	Independence, MO	Franklin Grove Living and Rehab, and Oregon Living			7
8			Beauvais Manor Healthcare and Rehab	St. Louis, MO	and Rehab			8
9			Hillside Manor Healthcare and Rehab	St. Louis, MO				9
10			Rancho Manor Healthcare Center	Florissant, MO				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (January-February)	100.00%	$ 16	$ 16	15
16	V	3	Housekeeping		SW Management Co. (January-February)	100.00%	9	9	16
17	V	5	Heat and Other Utilities		SW Management Co. (January-February)	100.00%	118	118	17
18	V	6	Maintenance		SW Management Co. (January-February)	100.00%	46	46	18
19	V	17	Administrative	3,850	SW Management Co. (January-February)	100.00%	3,222	(628)	19
20	V	19	Professional Services		SW Management Co. (January-February)	100.00%	112	112	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (January-February)	100.00%	10	10	21
22	V	21	Clerical & General Office Expense		SW Management Co. (January-February)	100.00%	4,115	4,115	22
23	V	24	Travel and Seminar		SW Management Co. (January-February)	100.00%	2	2	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (January-February)	100.00%	183	183	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (January-February)	100.00%	33	33	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (January-February)	100.00%	1,459	1,459	26
27	V	30	Depreciation		SW Management Co. (January-February)	100.00%	374	374	27
28	V	32	Interest		SW Management Co. (January-February)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (January-February)	100.00%	292	292	29
30	V	34	Rent - Facility & Grounds		SW Management Co. (January-February)	100.00%			30
31	V	35	Rent - Equipment & Vehicles		SW Management Co. (January-February)	100.00%	91	91	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,850			$ 10,082	$ * 6,232	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (March)	100.00%	$ 9	$ 9	15
16	V	3	Housekeeping		SW Management Co. (March)	100.00%	5	5	16
17	V	5	Utilities		SW Management Co. (March)	100.00%	69	69	17
18	V	6	Maintenance		SW Management Co. (March)	100.00%	27	27	18
19	V	17	Administrative	1,925	SW Management Co. (March)	100.00%	1,934	9	19
20	V	19	Professional Services		SW Management Co. (March)	100.00%	66	66	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Management Co. (March)	100.00%	6	6	21
22	V	21	Clerical & General Office Expenses		SW Management Co. (March)	100.00%	2,813	2,813	22
23	V	24	Travel & Seminar		SW Management Co. (March)	100.00%	1	1	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (March)	100.00%	108	108	24
25	V	26	Insurance - Prop.Liab.Malpractice		SW Management Co. (March)	100.00%	20	20	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (March)	100.00%	860	860	26
27	V	30	Depreciation		SW Management Co. (March)	100.00%	187	187	27
28	V	33	Real Estate Taxes		SW Management Co. (March)	100.00%	172	172	28
29	V	35	Rent - Equipment & Vehicles		SW Management Co. (March)	100.00%	54	54	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			$ 1,925			$ 6,331	$ * 4,406	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (April thru June)	100.00%	$ 30	$ 30	15
16	V	3	Housekeeping		SW Management Co. (April thru June)	100.00%	18	18	16
17	V	5	Utilities		SW Management Co. (April thru June)	100.00%	227	227	17
18	V	6	Maintenance		SW Management Co. (April thru June)	100.00%	89	89	18
19	V	17	Administrative	5,775	SW Management Co. (April thru June)	100.00%	6,766	991	19
20	V	19	Professional Services		SW Management Co. (April thru June)	100.00%	216	216	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Management Co. (April thru June)	100.00%	19	19	21
22	V	21	Clerical & General Office Expenses		SW Management Co. (April thru June)	100.00%	9,215	9,215	22
23	V	24	Travel & Seminar		SW Management Co. (April thru June)	100.00%	4	4	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (April thru June)	100.00%	354	354	24
25	V	26	Insurance - Prop.Liab.Malpractice		SW Management Co. (April thru June)	100.00%	64	64	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (April thru June)	100.00%	2,815	2,815	26
27	V	30	Depreciation		SW Management Co. (April thru June)	100.00%	561	561	27
28	V	33	Real Estate Taxes		SW Management Co. (April thru June)	100.00%	563	563	28
29	V	35	Rent - Equipment & Vehicles		SW Management Co. (April thru June)	100.00%	175	175	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			$ 5,775			$ 21,116	$ * 15,341	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (July-August)	100.00%	$ 20	$ 20	15
16	V	3	Housekeeping		SW Management Co. (July-August)	100.00%	12	12	16
17	V	5	Utilities		SW Management Co. (July-August)	100.00%	151	151	17
18	V	6	Maintenance		SW Management Co. (July-August)	100.00%	59	59	18
19	V	17	Administrative	3,850	SW Management Co. (July-August)	100.00%	4,512	662	19
20	V	19	Professional Services		SW Management Co. (July-August)	100.00%	144	144	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Management Co. (July-August)	100.00%	13	13	21
22	V	21	Clerical & General Office Expenses		SW Management Co. (July-August)	100.00%	6,143	6,143	22
23	V	24	Travel & Seminar		SW Management Co. (July-August)	100.00%	2	2	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (July-August)	100.00%	236	236	24
25	V	26	Insurance - Prop.Liab.Malpractice		SW Management Co. (July-August)	100.00%	43	43	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (July-August)	100.00%	1,877	1,877	26
27	V	30	Depreciation		SW Management Co. (July-August)	100.00%	374	374	27
28	V	33	Real Estate Taxes		SW Management Co. (July-August)	100.00%	376	376	28
29	V	35	Rent - Equipment & Vehicles		SW Management Co. (July-August)	100.00%	117	117	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,850			$ 14,079	$ * 10,229	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (September thru December)	100.00%	$ 40	$ 40	15
16	V	3	Housekeeping		SW Management Co. (September thru December)	100.00%	24	24	16
17	V	5	Utilities		SW Management Co. (September thru December)	100.00%	303	303	17
18	V	6	Maintenance		SW Management Co. (September thru December)	100.00%	119	119	18
19	V	17	Administrative	7,700	SW Management Co. (September thru December)	100.00%	4,511	(3,189)	19
20	V	19	Professional Services		SW Management Co. (September thru December)	100.00%	288	288	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Management Co. (September thru December)	100.00%	26	26	21
22	V	21	Clerical & General Office Expenses		SW Management Co. (September thru December)	100.00%	12,286	12,286	22
23	V	24	Travel & Seminar		SW Management Co. (September thru December)	100.00%	5	5	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (September thru December)	100.00%	472	472	24
25	V	26	Insurance - Prop.Liab.Malpractice		SW Management Co. (September thru December)	100.00%	86	86	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (September thru December)	100.00%	3,754	3,754	26
27	V	30	Depreciation		SW Management Co. (September thru December)	100.00%	748	748	27
28	V	33	Real Estate Taxes		SW Management Co. (September thru December)	100.00%	751	751	28
29	V	35	Rent - Equipment & Vehicles		SW Management Co. (September thru December)	100.00%	234	234	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			$ 7,700			$ 23,647	$ * 15,947	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 100	S & E Medical Supply Co.	100.00%	$ 81	$ (19)	15
16	V	10	Medical Supplies		S & E Medical Supply Co.	100.00%	10	10	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			$ 100			$ 91	$ * (9)	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 7,639	$ 7,639	15
16	V	32	Interest - Bonds	80,553	SFO Associates	0.00%	28,287	(52,266)	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			$ 80,553			$ 35,926	$ * (44,627)	39

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 9,667	L17, C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2	4.76	Salary	9,667	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	$ 19,334		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, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (January-February)
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	124,018	12	$ 358	$	5,369	$ 16	1
2	3	Housekeeping	Bed Days Available	124,018	12	213		5,369	9	2
3	5	Heat and Other Utilities	Bed Days Available	124,018	12	2,716		5,369	118	3
4	6	Maintenance	Bed Days Available	124,018	12	1,066		5,369	46	4
5	19	Professional Services	Bed Days Available	124,018	12	2,591		5,369	112	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	124,018	12	229		5,369	10	6
7	21	Clerical & General Office Exp	Bed Days Available	124,018	12	95,042	95,042	5,369	4,115	7
8	24	Travel and Seminar	Bed Days Available	124,018	12	42		5,369	2	8
9	25	Other Admin. Staff Transport	Bed Days Available	124,018	12	4,236		5,369	183	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	124,018	12	772		5,369	33	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	124,018	12	33,703		5,369	1,459	11
12	32	Interest	Bed Days Available	124,018	12			5,369	0	12
13	33	Real Estate Taxes	Bed Days Available	124,018	12	6,744		5,369	292	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	124,018	12	2,099		5,369	91	14
15										15
16	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	2	1,611	16
17	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	2	1,611	17
18	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	0	0	18
19										19
20	30	Depreciation	Direct Cost	6,938	12				374	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 251,310	$ 196,541		$ 10,082	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (March)
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	55,304	11	$ 179	$	2,821	$ 9	1
2	3	Housekeeping	Bed Days Available	55,304	11	106		2,821	5	2
3	5	Utilities	Bed Days Available	55,304	11	1,358		2,821	69	3
4	6	Maintenance	Bed Days Available	55,304	11	532		2,821	27	4
5	19	Professional Services	Bed Days Available	55,304	11	1,294		2,821	66	5
6	20	Dues, Fees, Subscriptions & Promotic	Bed Days Available	55,304	11	115		2,821	6	6
7	21	Clerical & General Office Expenses	Bed Days Available	55,304	11	55,153	47,522	2,821	2,813	7
8	24	Travel & Seminar	Bed Days Available	55,304	11	22		2,821	1	8
9	25	Other Admin. Staff Transport	Bed Days Available	55,304	11	2,118		2,821	108	9
10	26	Insurance - Prop.Liab.Malpractice	Bed Days Available	55,304	11	386		2,821	20	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	55,304	11	16,851		2,821	860	11
12	33	Real Estate Taxes	Bed Days Available	55,304	11	3,372		2,821	172	12
13	35	Rent - Equipment & Vehicles	Bed Days Available	55,304	11	1,050		2,821	54	13
14										14
15	17	Administrative - Salary	Average Hours Worked	35	11	16,917	16,917	2	967	15
16	17	Administrative - Salary	Average Hours Worked	35	11	16,917	16,917	2	967	16
17	17	Administrative - Salary	Average Hours Worked	40	3	16,917	16,917			17
18										18
19	30	Depreciation	Direct Cost	3,469					187	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 133,287	$ 98,273		$ 6,331	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (April thru June)
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	148,694	10	$ 537	$	8,281	$ 30	1
2	3	Housekeeping	Bed Days Available	148,694	10	320		8,281	18	2
3	5	Utilities	Bed Days Available	148,694	10	4,074		8,281	227	3
4	6	Maintenance	Bed Days Available	148,694	10	1,599		8,281	89	4
5	19	Professional Services	Bed Days Available	148,694	10	3,886		8,281	216	5
6	20	Dues, Fees, Subscriptions & Promotic	Bed Days Available	148,694	10	344		8,281	19	6
7	21	Clerical & General Office Expenses	Bed Days Available	148,694	10	165,455	142,564	8,281	9,215	7
8	24	Travel & Seminar	Bed Days Available	148,694	10	64		8,281	4	8
9	25	Other Admin. Staff Transport	Bed Days Available	148,694	10	6,354		8,281	354	9
10	26	Insurance - Prop.Liab.Malpractice	Bed Days Available	148,694	10	1,158		8,281	64	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	148,694	10	50,553		8,281	2,815	11
12	33	Real Estate Taxes	Bed Days Available	148,694	10	10,116		8,281	563	12
13	35	Rent - Equipment & Vehicles	Bed Days Available	148,694	10	3,149		8,281	175	13
14										14
15	17	Administrative - Salary	Average Hours Worked	30	10	50,750	50,750	2	3,383	15
16	17	Administrative - Salary	Average Hours Worked	30	10	50,750	50,750	2	3,383	16
17	17	Administrative - Salary	Average Hours Worked	40	3	50,750	50,750			17
18										18
19	30	Depreciation	Direct Cost	10,408					561	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 399,859	$ 294,814		$ 21,116	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (July-August)
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	101,308	10	$ 358	$	5,642	$ 20	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		5,642	12	2
3	5	Utilities	Bed Days Available	101,308	10	2,716		5,642	151	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		5,642	59	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		5,642	144	5
6	20	Dues, Fees, Subscriptions & Promotic	Bed Days Available	101,308	10	229		5,642	13	6
7	21	Clerical & General Office Expenses	Bed Days Available	101,308	10	110,303	95,042	5,642	6,143	7
8	24	Travel & Seminar	Bed Days Available	101,308	10	42		5,642	2	8
9	25	Other Admin. Staff Transport	Bed Days Available	101,308	10	4,236		5,642	236	9
10	26	Insurance - Prop.Liab.Malpractice	Bed Days Available	101,308	10	772		5,642	43	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		5,642	1,877	11
12	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		5,642	376	12
13	35	Rent - Equipment & Vehicles	Bed Days Available	101,308	10	2,099		5,642	117	13
14										14
15	17	Administrative - Salary	Average Hours Worked	30	10	33,833	33,833	2	2,256	15
16	17	Administrative - Salary	Average Hours Worked	30	10	33,833	33,833	2	2,256	16
17	17	Administrative - Salary	Average Hours Worked	40	3	33,833	33,833			17
18										18
19	30	Depreciation	Direct Cost	6,938					374	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 266,571	$ 196,541		$ 14,079	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. (September thru December
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	199,348	10	$ 716	$	11,102	$ 40	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		11,102	24	2
3	5	Utilities	Bed Days Available	199,348	10	5,432		11,102	303	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		11,102	119	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		11,102	288	5
6	20	Dues, Fees, Subscriptions & Promotic	Bed Days Available	199,348	10	458		11,102	26	6
7	21	Clerical & General Office Expenses	Bed Days Available	199,348	10	220,606	190,085	11,102	12,286	7
8	24	Travel & Seminar	Bed Days Available	199,348	10	86		11,102	5	8
9	25	Other Admin. Staff Transport	Bed Days Available	199,348	10	8,472		11,102	472	9
10	26	Insurance - Prop.Liab.Malpractice	Bed Days Available	199,348	10	1,543		11,102	86	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		11,102	3,754	11
12	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		11,102	751	12
13	35	Rent - Equipment & Vehicles	Bed Days Available	199,348	10	4,198		11,102	234	13
14										14
15	17	Administrative - Salary	Average Hours Worked	30	10	67,667	67,667	2	4,511	15
16										16
17	17	Administrative - Salary	Average Hours Worked	15	1	67,667	67,667			17
18										18
19	30	Depreciation	Direct Cost	13,877					748	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 465,476	$ 325,419		$ 23,647	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 81	1
2	10	Medical Supplies	Direct Cost						10	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					$	$		$ 91	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 29,209	$	1,700,000	$ 7,639	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	108,156		1,700,000	28,287	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					$ 137,365	$		$ 35,926	25

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 392,308	8/15/14	Variable	$ 28,287	1
2	(Loan Payable-SFO Assoc)											2
3												3
4												4
5												5
	Working Capital											
6	Shareholders' Loan	X		Working Capital				447,417		Varies	3,802	6
7												7
8												8
9	TOTAL Facility Related						$ 1,700,000	$ 839,725			$ 32,089	9
	B. Non-Facility Related*											
10								Amortization of loan costs			2,921	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,921	14
15	TOTALS (line 9+line14)						$ 1,700,000	$ 839,725			$ 35,010	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.)**

** **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, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)	2010	$ 37,467	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,633)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,600	4
	Mgmt. Alloc.	401	
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.)**		$ 2,077	5
	Mgmt. Alloc.	1,753	
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.		$ 29,198	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	46,340	8
	2007	48,724	9
	2008	49,589	10
	2009	49,612	11
	2010	37,467	12

RE Tax Accrual = 37,467 * 1.03 = 38,591. Use 38,600

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shabbona Healthcare Center, Inc. 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 2010 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 2010.

	(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	$ 37,466.00	$ 37,466.00
2.	10-28-412-049-0000	SW Management Allocation	$ 33,410.00	$ 1,753.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,876.00	$ 39,219.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 1,183,472	4
5											5
6	Allocation from Management Co.				23,329			667	667	11,101	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	6	(1,194)	65,810	10
11	Various			1991	20,536	460	20	319	(141)	20,536	11
12	Various			1992	5,466		10			4,191	12
13	Various			1993	13,848	393	20	685	292	12,591	13
14	Various			1994	39,334	1,009	20	1,967	958	34,976	14
15	Various			1995	13,479	178	20	674	496	12,150	15
16	Various			1996	11,533	160	20	577	417	9,810	16
17	Various			1997	18,996	487	20	950	463	14,061	17
18	Various			1998	141,664	3,693	20	7,021	3,328	97,511	18
19	Various			1999	2,415	62	20	121	59	1,532	19
20	Air Handler			2000	1,150		10			1,150	20
21	Air Handler			2000	1,870		10			1,870	21
22	Air Handler			2000	1,900		10	17	17	1,900	22
23	Driveway			2001	3,040	78	20	152	74	1,558	23
24	Nurses Call System			2001	2,745		10	136	136	2,745	24
25	Air Handler			2001	1,350		10	34	34	1,350	25
26	Security System			2001	1,507		10	101	101	1,507	26
27	Telephone System			2001	1,928		10	140	140	1,928	27
28	Heating and Cooling System			2002	1,078		20	54	54	516	28
29	Drapes			2003	1,528		10	153	153	1,338	29
30	Sidewalk Repair			2003	1,250		20	63	63	532	30
31	Wallpaper - North Dining Hall			2004	3,007	109	20	150	41	1,127	31
32	Air Handlers			2005	6,391	232	20	320	88	2,078	32
33	Windows, fascia and gutters & oversize downspouts			2005	60,785	2,210	20	3,039	829	19,755	33
34	Security control panel			2005	688	25	20	34	9	222	34
35	Patio & Fountain			2006	18,666	1,163	20	933	(230)	5,133	35
36	Fence			2006	2,008	125	20	100	(25)	551	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, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 1,005	37
38	Fire Alarm System	2006	5,392	196	20	270	74	1,484	38
39	Asphalt	2006	4,200	262	20	210	(52)	1,155	39
40	Landscaping	2006	99,698	6,211	20	4,985	(1,226)	27,417	40
41	Kitchen Air Conditioners	2007	5,193	598	20	260	(338)	1,169	41
42	Roof	2008	21,179	770	20	1,059	289	3,706	42
43	Kitchen Remodel-Repair & Replace W Wall, Plumbing, New	2008	16,036	583	20	802	219	2,807	43
44	Hand Sink, Replace Flooring Tiles								44
45	Hot Water Heater	2009	7,800	284	20	390	106	975	45
46									46
47	Repave Parking Lots	2010	6,798	323	20	340	17	510	47
48	Sealcoat Parking Lots	2010	2,610	124	20	131	7	196	48
49	Retaining Walls & Walkways	2010	16,190	769	20	796	27	1,177	49
50	Replanting Trees	2010	10,119		20	506	506	757	50
51	Remove and replace sidewalks	2011	17,386	17,386	20	435	(16,951)	435	51
52	Install cabinets for nurse's station	2011	19,000	374	20	475	101	475	52
53	Install Attic Heat Detector	2011	4,427	101	20	111	10	111	53
54	Plank Flooring	2011	46,744	921	20	1,169	248	1,169	54
55	Install fire dampers	2011	6,668	91	20	167	76	167	55
56	Install 4 ton Air Handler and 4 ton condensor	2011	15,694	309	20	392	83	392	56
57	Install 16 bathroom radiant exhaust fans	2011	7,000	53	20	175	122	175	57
58									58
59	Allocation from SW management - leasehold improvements	1995	2,611			130	130	2,352	59
60	Allocation from SW management - leasehold improvements	1996	435			22	22	338	60
61	Allocation from SW management - leasehold improvements	1997	504			25	25	428	61
62	Allocation from SW management - leasehold improvements	1998	431			22	22	296	62
63	Allocation from SW management - leasehold improvements	1999	1,197			60	60	723	63
64	Allocation from SW management - leasehold improvements	2005	2,475			124	124	804	64
65	Allocation from SW management - leasehold improvements	2007	1,401			70	70	315	65
66	Allocation from SW management - leasehold improvements	2009	2,926			146	146	366	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,439,478	$ 41,089		$ 99,651	$ 58,562	$ 1,566,554	70

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 94,207	$ 9,920	$ 10,041	$ 121	5-10	$ 36,420	71
72	Current Year Purchases	23,604	23,604	1,180	(22,424)	5-10	1,180	72
73	Fully Depreciated Assets	394,538					394,538	73
74	Allocated from Management Company	7,366		149	149		5,847	74
75	TOTALS	$ 519,715	$ 33,524	$ 11,370	$ (22,154)		$ 437,985	75

D. Vehicle Costs. (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	1,493		(1,493)	5	25,644	78
79	Allocated from Management	2010 Infiniti	2010	4,145		829	829		1,243	79
80	TOTALS			$ 84,963	$ 3,268	$ 829	$ (2,439)		$ 76,735	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)	$ 4,094,156	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,881	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,850	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,969	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,081,275	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, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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 Co.		$	$ 671	17
18					18
19					19
20					20
21	TOTAL		$	$ 671	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.

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	882	$ 98,795	$	882	$ 98,795	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		652	15,650		652	15,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		953	99,133		953	99,133	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				54,408		54,408	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			$	2,487	$ 213,578	$ 54,408	2,487	$ 267,986	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.

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 320,761	$ 320,761	1
2	Cash-Patient Deposits	30,870	30,870	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,223,307	1,223,307	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,298	1,298	6
7	Other Prepaid Expenses		281	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	861,588	3,289,728	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,437,824	$ 4,866,245	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		2,666,916	14
15	Leasehold Improvements, at Historical Cost	722,609	772,562	15
16	Equipment, at Historical Cost	418,792	604,678	16
17	Accumulated Depreciation (book methods)	(682,826)	(2,081,275)	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		36,186	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 458,575	$ 2,049,067	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,896,399	$ 6,915,312	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,768	$ 70,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,487	40,487	28
29	Short-Term Notes Payable	447,417	447,417	29
30	Accrued Salaries Payable	41,817	41,817	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,489	8,489	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,600	38,600	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	3,191,319	6,102,795	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,838,897	$ 6,750,373	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		392,308	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)**	$	$ 392,308	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,838,897	$ 7,142,681	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (942,498)	$ (227,369)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,896,399	$ 6,915,312	48

*(See instructions.)

Shabbona Healthcare Center, Inc.
0032169
12/31/11

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State	(100)	(100)
Due from State-Interest	4,120	4,120
Employee Loans	17,925	17,925
Employee Payroll Advance	1,030	1,030
Short Term Loan Exchange	12,040	12,040
Due from Shabbona Ret Cnt	826,573	826,573
RE Due from Shabbona Healthcare	-	2,428,140
Total Line 9 - Other Current Assets (specify):	861,588	3,289,728

Other (specify):	Operating	After Consolidation
Investment in SFO	-	(257)
Loan Costs	-	87,616
Acc. Amortization of Loan Costs	-	(51,173)
Total Line 22 - Other Current Liabilities (specify):	-	36,186

Other Current Liabilities (specify):	Operating	After Consolidation
Reimbursement Due	88,687	88,687
Insurance Premiums payable	371	371
Acc. Retirement (From P/R)		
Accrued Expenses	219,755	219,755
Accrued Management Fees		
Short Term Loan Exchange	453,803	453,803
Due to Public Aid	563	563
Due To/From Shabbona LLC	2,428,140	2,428,140
RE due to/from - SFO		2,911,476
Total Line 36 - Other Current Liabilities (specify):	3,191,319	6,102,795

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (751,108)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (751,108)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(191,392)	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)**	$ (191,390)	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)**	$ (942,498)	24	*

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

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 3,925,659	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,925,659	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	186,473	6
7	Oxygen	2,089	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 188,562	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	1,635	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,635	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,798	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,798	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adj & Misc Inc	5,669	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,669	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,142,323	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	994,082	31
32	Health Care	1,956,590	32
33	General Administration	805,699	33
	B. Capital Expense		
34	Ownership	445,720	34
	C. Ancillary Expense		
35	Special Cost Centers	81,801	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)***	$ 4,333,715	40
41	**Income before Income Taxes (line 30 minus line 40)****	(191,392)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (191,392)	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.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,040	2,080	$ 64,455	$ 30.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,050	8,699	240,502	27.65	3
4	Licensed Practical Nurses	12,317	13,456	324,745	24.13	4
5	CNAs & Orderlies	54,585	58,121	614,942	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,628	10,461	106,212	10.15	10
11	Social Service Workers	2,302	2,533	35,940	14.19	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,373	16.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,187	23,250	209,924	9.03	15
16	Dishwashers					16
17	Maintenance Workers	2,422	2,437	49,658	20.37	17
18	Housekeepers	15,816	16,630	152,489	9.17	18
19	Laundry	6,017	6,302	53,671	8.52	19
20	Administrator	2,040	2,080	65,673	31.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	640	678	10,973	16.20	23
24	Clerical	9,959	10,463	187,470	17.92	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)	150,083	159,269	$ 2,151,027 *	$ 13.51	34

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

** See instructions.

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	108	$ 4,330	L1, C3	35
36	Medical Director	221	11,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	22	1,051	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	138	6,610	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	152	7,279	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	641	$ 30,770		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	5,186	248,943	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,186	$ 248,943		53

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eileen Gates	Administrator	0	$ 5,943
Sherri Whitmer	Administrator	0	59,730
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,673

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/E Consultant	$ 1,590
McGladrey & Pullen LLP	Accounting	17,300
Honkamp & Kruerger Co	Accounting	505
Margel S. Peddicord, CPA	Accounting	1,970
Stone McGuire & Siegel	Legal	1,823
Allen Lefkowitz	Legal	2,077
Gallop, Johnson & Heuman LC	Legal	366
Polsinelli Shughart PC	Legal	582
Ashman & Stein	Legal	3,646
Huron Consulting Services Inc.	Valuation Consulting	3,140
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 32,999

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,600
Unemployment Compensation Insurance	26,185
FICA Taxes	164,530
Employee Health Insurance	41,583
Employee Meals	5,581
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	3,200
Holiday Expense	2,562
Employee Life Insurance	3,059
TOTAL (agree to Schedule V, line 22, col.8)	$ 355,300

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 361	4,330
Illinois Council on Long Term Care	6,854
Miscellaneous Dues & Permits	1,334
Miscellaneous Inspections & Licenses	1,260
Allocated from Management Co.	74
Allocated from RE Entity	426
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,278

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,559
Allocated from Management Co.	14
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,573

**See instructions.

Shabbona Healthcare Center, Inc.
0032169
12/31/11 **Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		**32,999**
Less Reclass of Allen Lefkowitz invoices		(2,077)
Allocated from Shabbona Building Associates LLC		
	Accounting	2,635
Allocated from SFO Associates		7,639
	Accounting	
Allocated from Management Company		
	Legal	103
	Accounting - RSM McGladrey	723
Total (agree to Schedule V, line 19, column 8)		**42,022**

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shabbona Healthcare Center, Inc. # 0032169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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-$6,854**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **18,345** 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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **5,581** 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 fo
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 othe
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
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