

Facility Name & ID Number Wauconda HealthCare and Rehabilitation

0044859 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>117</u>	Skilled (SNF)	<u>117</u>	<u>42,705</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>117</u>	TOTALS	<u>117</u>	<u>42,705</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>11,299</u>	<u>4,328</u>	<u>4,064</u>	<u>19,691</u>	8
9	SNF/PED					9
10	ICF	<u>17,387</u>	<u>3,805</u>	<u>640</u>	<u>21,832</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,686</u>	<u>8,133</u>	<u>4,704</u>	<u>41,523</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.23%

D. How many bed-hold days during this year were paid by Public Aid?

66 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1-May-2000

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

YES Date 1-May-2000 NO

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

YES NO If YES, enter number of beds certified 117 and days of care provided 3,408

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31-Dec-2003 Fiscal Year: 31-Dec-2003

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

STATE OF ILLINOIS

Facility Name & ID Number Wauconda HealthCare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	254,638	19,315	8,974	282,927		282,927		282,927		1
2	Food Purchase		156,842		156,842	(9,691)	147,151	(289)	146,862		2
3	Housekeeping	202,332	35,035		237,367		237,367		237,367		3
4	Laundry	48,038	33,432		81,470		81,470		81,470		4
5	Heat and Other Utilities			104,467	104,467		104,467		104,467		5
6	Maintenance	36,216	19,411	49,876	105,503		105,503	2,576	108,079		6
7	Other (specify):*										7
8	TOTAL General Services	541,224	264,035	163,317	968,576	(9,691)	958,885	2,287	961,172		8
	B. Health Care and Programs										
9	Medical Director			9,100	9,100		9,100		9,100		9
10	Nursing and Medical Records	1,897,214	113,881	34,128	2,045,223		2,045,223		2,045,223		10
10a	Therapy			5,183	5,183		5,183		5,183		10a
11	Activities	65,271	18,027		83,298		83,298		83,298		11
12	Social Services	36,469		3,213	39,682		39,682		39,682		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,998,954	131,908	51,624	2,182,486		2,182,486		2,182,486		16
	C. General Administration										
17	Administrative	130,663		171,990	302,653		302,653	(126,234)	176,419		17
18	Directors Fees										18
19	Professional Services			36,782	36,782		36,782	12,015	48,797		19
20	Dues, Fees, Subscriptions & Promotions			60,859	60,859		60,859	(36,670)	24,189		20
21	Clerical & General Office Expenses	154,003	21,700	34,167	209,870		209,870	57,097	266,967		21
22	Employee Benefits & Payroll Taxes			390,123	390,123	9,691	399,814	48,994	448,808		22
23	Inservice Training & Education			1,414	1,414		1,414		1,414		23
24	Travel and Seminar			4,747	4,747		4,747	6,347	11,094		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,087	18,087		18,087		18,087		26
27	Other (specify):* **Payroll Taxes**							7,780	7,780		27
28	TOTAL General Administration	284,666	21,700	718,169	1,024,535	9,691	1,034,226	(30,671)	1,003,555		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,824,844	417,643	933,110	4,175,597		4,175,597	(28,384)	4,147,213		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.

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Facility Name & ID Number Wauconda HealthCare and Rehabilitation #0044859 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			59,748	59,748		59,748	(17,134)	42,614		30
31	Amortization of Pre-Op. & Org.							2,901	2,901		31
32	Interest			3,218	3,218		3,218	480,959	484,177		32
33	Real Estate Taxes			55,766	55,766		55,766		55,766		33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(770,760)	429,240		34
35	Rent-Equipment & Vehicles			14,119	14,119		14,119		14,119		35
36	Other (specify):*										36
37	TOTAL Ownership			1,332,851	1,332,851		1,332,851	(304,034)	1,028,817		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		72,746	118,788	191,534		191,534		191,534		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			64,057	64,057		64,057		64,057		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		72,746	182,845	255,591		255,591		255,591		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,824,844	490,389	2,448,806	5,764,039		5,764,039	(332,418)	5,431,621		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 Wauconda HealthCare and Rehabilitation

0044859

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(17,819)	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	(289)	2		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,035)	21		24
25	Fund Raising, Advertising and Promotional	(58,266)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,233)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(303)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,945)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(244,473)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (244,473)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (332,418)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Wauconda HealthCare and Rehabilitation

ID# 0044859

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda HealthCare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(289)	0	0	0	0	0	0	0	0	0	0	(289)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	2,576	0	0	0	0	0	0	0	0	0	2,576	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(289)	2,576	0	0	0	0	0	0	0	0	0	2,287	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(126,234)	0	0	0	0	0	0	0	0	0	(126,234)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,015	0	0	0	0	0	0	0	0	0	12,015	19
20	Fees, Subscriptions & Promotions	(58,569)	21,899	0	0	0	0	0	0	0	0	0	(36,670)	20
21	Clerical & General Office Expenses	(11,268)	67,132	1,233	0	0	0	0	0	0	0	0	57,097	21
22	Employee Benefits & Payroll Taxes	0	48,994	0	0	0	0	0	0	0	0	0	48,994	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,347	0	0	0	0	0	0	0	0	0	6,347	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	7,780	0	0	0	0	0	0	0	0	0	7,780	27
28	TOTAL General Administration	(69,837)	37,933	1,233	0	(30,671)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,126)	40,509	1,233	0	(28,384)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda HealthCare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(17,819)	685	0	0	0	0	0	0	0	0	0	(17,134) 30
31	Amortization of Pre-Op. & Org.	0	0	2,901	0	0	0	0	0	0	0	0	2,901 31
32	Interest	0	9,515	471,444	0	0	0	0	0	0	0	0	480,959 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	(770,760)	0	0	0	0	0	0	0	0	(770,760) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(17,819)	10,200	(296,415)	0	(304,034) 37							
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(87,945)	50,709	(295,182)	0	(332,418) 45							

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 42,382	\$ 42,382 1
2	V	27 Payroll Taxes - Officers		Lancaster, Ltd.	100.00%	2,238	2,238 2
3	V	17 Management Fee Income	171,990	Lancaster, Ltd.	100.00%		(171,990) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	12,015	12,015 4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	67,132	67,132 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	48,994	48,994 6
7	V	24 Education, Seminars & Travel		Lancaster, Ltd.	100.00%	6,347	6,347 7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	3,374	3,374 8
9	V	20 Fees & Marketing		Lancaster, Ltd.	100.00%	21,899	21,899 9
10	V	32 Interest	3,218	Lancaster, Ltd.	100.00%	12,733	9,515 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	685	685 11
12	V	6 Maintenance		Lancaster, Ltd.	100.00%	2,576	2,576 12
13	V	27 Payroll Taxes - Clerical		Lancaster, Ltd.	100.00%	5,542	5,542 13
14	Total		\$ 175,208			\$ 225,917	\$ * 50,709 14

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

Facility Name & ID Number Wauconda HealthCare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rental	\$ 1,200,000	Wauconda Associates	100.00%	\$ 429,240	\$ (770,760)
16	V	32 Interest	8,556	Wauconda Associates	100.00%	480,000	471,444
17	V	31 Amortization		Wauconda Associates	100.00%	2,901	2,901
18	V	21 Illinois Replacement Tax		Wauconda Associates	100.00%	1,233	1,233
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,208,556			\$ 913,374	\$ * (295,182)

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

Facility Name & ID Number Wauconda HealthCare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Laurence Zung	Executive Officer	Administrative	33.34%	see attached	2	4.17%	Lancaster	\$ 14,221	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	see attached	5	10.42%	Lancaster	15,420	17-7	2
3	Cheryl Morris	VP-Operation	Administrative	0.00	see attached	5	10.42%	Lancaster	12,741	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,382		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 Wauconda HealthCare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-03 Ending: 1-Dec-03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)478.3699
 Fax Number (773)478.1192

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

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	17	Laurence Zung	Hours Worked	48	7	\$ 341,304	\$ 341,304	2	\$ 14,221	1
2	27	Laurence Zung	Hours Worked	48	7	11,443	0	2	477	2
3	17	Christopher Vicere	Hours Worked	48	7	148,036	148,036	5	15,420	3
4	27	Christopher Vicere	Hours Worked	48	7	8,641	0	5	900	4
5	17	Cheryl Morris	Hours Worked	48	7	122,314	122,314	5	12,741	5
6	27	Cheryl Morris	Hours Worked	48	7	8,268	0	5	861	6
7										7
8										8
9	19	Professional Services	Management Fees	1,974,210	7	137,913	0	171,990	12,015	9
10	21	Clerical Expenses	Management Fees	1,974,210	7	58,516	0	171,990	5,098	10
11	22	Employee Benefits	Management Fees	1,974,210	7	562,384	0	171,990	48,994	11
12	24	Education and Seminars	Management Fees	1,974,210	7	23,865	0	171,990	2,079	12
13	17	Administrative Consultant	Management Fees	1,974,210	7	38,732	38,732	171,990	3,374	13
14	20	Marketing	Management Fees	1,974,210	7	245,986	171,548	171,990	21,430	14
15	32	Interest	Management Fees	1,974,210	7	47,944	0	171,990	4,177	15
16	30	Depreciation	Management Fees	1,974,210	7	7,864	0	171,990	685	16
17	20	Licenses and Fees	Management Fees	1,974,210	7	5,379	0	171,990	469	17
18	6	Maintenance	Management Fees	1,974,210	7	29,570	0	171,990	2,576	18
19	24	Travel	Management Fees	1,974,210	7	48,990	0	171,990	4,268	19
20	21	Salaries - Clerical	Management Fees	1,974,210	7	712,068	712,068	171,990	62,034	20
21	27	Payroll Taxes - Clerical	Management Fees	1,974,210	7	63,611	0	171,990	5,542	21
22	32	Direct Interest							5,338	22
23										23
24										24
25	TOTALS					\$ 2,622,828	\$ 1,534,002		\$ 222,699	25

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**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
	Working Capital																			
6	Bank One		X	Working Capital							4,177	6								
7	Harston Investments		X	Working Capital							480,000	7								
8												8								
9	TOTAL Facility Related					\$	\$			\$	484,177	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related					\$	\$			\$		14								
15	TOTALS (line 9+line14)					\$	\$			\$	484,177	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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 **Wauconda HealthCare and Rehabilitation**# **0044859** Report Period Beginning: **1-Jan-03** Ending: **31-Dec-03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2002 report.			\$	58,700	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.)			\$	56,766	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	(1,934)	3																			
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	57,700	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.)			\$		5																			
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. 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.			\$	55,766	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1998	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	1999	54,589	9																						
	2000	56,580	10																						
	2001	59,283	11																						
	2002	55,766	12																						
**																									

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wauconda HealthCare and Rehabilitation COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-35-200-009</u>	<u>Long-Term HealthCare</u>	\$ <u>50,277.42</u>	\$ <u>50,277.42</u>
2. <u>09-35-200-059</u>	<u>Long-Term HealthCare</u>	\$ <u>6,291.07</u>	\$ <u>6,291.07</u>
3. <u>09-35-200-057</u>	<u>Long-Term HealthCare</u>	\$ <u>197.49</u>	\$ <u>197.49</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>56,765.98</u>	\$ <u>56,765.98</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Wauconda HealthCare and Rehabilitation# 0044859 Report Period Beginning:1-Jan-03 Ending:31-Dec-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 14,507 2. Number of Years Over Which it is Being Amortized: 53. Current Period Amortization: 2,901 4. Dates Incurred: 1-May-2000

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Wauconda HealthCare and Rehabilitation

0044859

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Redwood Sign 4x6		2000		2,862	226	20	226		828	9
10	Nurses' Call System		2001		18,785	2,588	20	3,697	1,109	9,543	10
11	Fire Protection System		2001		99,420	13,696	20	19,565	5,869	50,507	11
12	Nurse Call Additions		2002		1,100	189	20	73	(116)	97	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

*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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 122,167	\$ 16,699		\$ 23,561	\$ 6,862	\$ 60,975		70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 83,665	\$ 14,991	\$ 13,900	\$ (1,091)	10	\$ 55,633	71
72	Current Year Purchases	50,360	28,743	5,153	(23,590)	10	5,153	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 134,025	\$ 43,734	\$ 19,053	\$ (24,681)		\$ 60,786	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 256,192	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,433	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,614	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,819)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 121,761	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wauconda Associates **an unrelated entity**
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>429,240</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>429,240</u>			7

10. Effective dates of current rental agreement:
 Beginning 1-May-2000
 Ending 30-April-2007

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2004</u>	\$ <u>429,240</u>
13.	<u>12/31/2005</u>	\$ <u>429,240</u>
14.	<u>12/31/2006</u>	\$ <u>462,029</u>

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 14,119 Description: Laundry Washer \$2,607 (@217.25 p.m.) & Copier \$11,512 (@ 959.33 p.m.)
 (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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 51,689	\$		\$ 51,689	1
2	Licensed Speech and Language Development Therapist		hrs			1,462			1,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			65,637			65,637	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				64,734		64,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies ** Other (specify): **Specialty Beds**						5,905 2,107		5,905 2,107	13
14	TOTAL			\$		\$ 118,788	\$ 72,746		\$ 191,534	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wauconda HealthCare and Rehabilitation

0044859

Report Period Beginning: 1-Jan-03

Ending:

31-Dec-03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-03

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,461	\$ 10,461	1
2	Cash-Patient Deposits	49,953	49,953	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,291,508	1,291,508	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,149	27,149	6
7	Other Prepaid Expenses	61,928	61,928	7
8	Accounts Receivable (owners or related parties)	1,910	419,743	8
9	Other(specify): **Refundable Deposit**	582	582	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,443,491	\$ 1,861,324	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	122,167	122,167	15
16	Equipment, at Historical Cost	134,025	134,025	16
17	Accumulated Depreciation (book methods)	(169,958)	(169,958)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,638)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe *Option Deposit*)		3,600,000	22
23	Other(specify): **Construction in Progress**		15,205	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 86,234	\$ 3,705,308	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,529,725	\$ 5,566,632	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 99,447	\$ 99,447	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,953	49,953	28
29	Short-Term Notes Payable	133,154		29
30	Accrued Salaries Payable	200,906	200,906	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,937	8,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,700	57,700	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 550,097	\$ 416,943	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,000,000	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)	\$	\$ 4,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 550,097	\$ 4,416,943	46
47	TOTAL EQUITY(page 18, line 24)	\$ 979,628	\$ 1,149,689	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,529,725	\$ 5,566,632	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 639,870	1
2	Restatements (describe):		2
3			3
4	**Adjustment of Book Depreciation for Tax	(5,299)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 634,571	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	345,057	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 345,057	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)	\$ 979,628	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 514,749	1
2	Restatements (describe):		2
3			3
4	**Adjustment of Book Depreciation for Tax	(5,299)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 509,450	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	640,239	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 640,239	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)	\$ 1,149,689	24 *

* This must agree with page 17, line 47, col 2.

Facility Name & ID Number Wauconda HealthCare and Rehabilitation

0044859

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,290,419	1
2	Discounts and Allowances for all Levels	(756,516)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,533,903	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	443,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 443,460	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	114,278	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,848	19
20	Radiology and X-Ray	2,400	20
21	Other Medical Services	5,207	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 131,733	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		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)	\$ 6,109,096	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	968,576	31
32	Health Care	2,182,486	32
33	General Administration	1,024,535	33
B. Capital Expense			
34	Ownership	1,332,851	34
C. Ancillary Expense			
35	Special Cost Centers	191,534	35
36	Provider Participation Fee	64,057	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,764,039	40
41	Income before Income Taxes (line 30 minus line 40)**	345,057	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 345,057	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. *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 **Wauconda HealthCare and Rehabilitation**# **0044859**Report Period Beginning: **1-Jan-03**Ending: **31-Dec-03**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,813	1,946	\$ 65,955	\$ 33.89	1
2	Assistant Director of Nursing	524	543	12,954	23.86	2
3	Registered Nurses	29,697	32,463	791,628	24.39	3
4	Licensed Practical Nurses	4,060	4,469	102,814	23.01	4
5	Nurse Aides & Orderlies	66,907	73,260	896,656	12.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,435	1,886	29,209	15.49	9
10	Activity Assistants	3,905	4,199	36,062	8.59	10
11	Social Service Workers	2,974	3,114	36,469	11.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,001	25,421	254,638	10.02	15
16	Dishwashers					16
17	Maintenance Workers	2,368	2,535	36,216	14.29	17
18	Housekeepers	23,236	25,292	202,332	8.00	18
19	Laundry	5,329	5,927	48,038	8.10	19
20	Administrator	1,936	2,086	81,677	39.15	20
21	Assistant Administrator	1,748	1,947	48,986	25.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,520	11,522	154,003	13.37	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	1,994	2,096	27,207	12.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,447	198,706	\$ 2,824,844 *	\$ 14.22	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	224	\$ 8,974	1-3	35
36	Medical Director	245	9,100	9-3	36
37	Medical Records Consultant	109	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	103	5,183	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	87	3,213	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	768	\$ 30,598		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	714	\$ 30,000	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	714	\$ 30,000		53

Facility Name & ID Number Wauconda HealthCare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long-Term Care \$ 4,068
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 16,470 Line 10-2
- (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 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 64,057
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 9,691 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? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.