

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

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 _____

	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>42,822</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>42,822</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>10,031</u>	<u>2,715</u>	<u>4,149</u>	<u>16,895</u>	8
9	SNF/PED					9
10	ICF	<u>20,097</u>	<u>4,036</u>		<u>24,133</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,128</u>	<u>6,751</u>	<u>4,149</u>	<u>41,028</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.81%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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 4,125

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-2004 Fiscal Year: 31-Dec-2004

* 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-04 Ending: 31-Dec-04

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	256,250	19,151	10,276	285,677		285,677		285,677		1
2	Food Purchase		190,663		190,663	(10,476)	180,187	(293)	179,894		2
3	Housekeeping	219,524	46,075		265,599		265,599		265,599		3
4	Laundry	36,704	29,128		65,832		65,832		65,832		4
5	Heat and Other Utilities			121,051	121,051		121,051		121,051		5
6	Maintenance	33,598	53,287	72,674	159,559		159,559	(7,095)	152,464		6
7	Other (specify):*										7
8	TOTAL General Services	546,076	338,304	204,001	1,088,381	(10,476)	1,077,905	(7,388)	1,070,517		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,917,093	105,246	79,220	2,101,559		2,101,559		2,101,559		10
10a	Therapy										10a
11	Activities	47,278	10,280		57,558		57,558		57,558		11
12	Social Services	40,238		2,160	42,398		42,398		42,398		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,004,609	115,526	89,780	2,209,915		2,209,915		2,209,915		16
	C. General Administration										
17	Administrative	89,674		203,580	293,254		293,254	(131,414)	161,840		17
18	Directors Fees										18
19	Professional Services			70,596	70,596		70,596	4,936	75,532		19
20	Dues, Fees, Subscriptions & Promotions			32,738	32,738		32,738	(21,225)	11,513		20
21	Clerical & General Office Expenses	171,790	30,313	87,343	289,446		289,446	5,127	294,573		21
22	Employee Benefits & Payroll Taxes			443,654	443,654	10,476	454,130	32,683	486,813		22
23	Inservice Training & Education			470	470		470		470		23
24	Travel and Seminar			8,233	8,233		8,233	4,159	12,392		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,750	9,750		9,750		9,750		26
27	Other (specify):* Payroll Taxes (Sch. VII)**							8,681	8,681		27
28	TOTAL General Administration	261,464	30,313	856,364	1,148,141	10,476	1,158,617	(97,053)	1,061,564		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,812,149	484,143	1,150,145	4,446,437		4,446,437	(104,441)	4,341,996		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 Wauconda Healthcare and Rehabilitation #0044859 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

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			53,641	53,641		53,641	(12,893)	40,748			30
31	Amortization of Pre-Op. & Org.							2,901	2,901			31
32	Interest							491,349	491,349			32
33	Real Estate Taxes			59,629	59,629		59,629		59,629			33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(770,760)	429,240			34
35	Rent-Equipment & Vehicles			12,409	12,409		12,409		12,409			35
36	Other (specify):*											36
37	TOTAL Ownership			1,325,679	1,325,679		1,325,679	(289,403)	1,036,276			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,850	236,842	338,692		338,692		338,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,233	64,233		64,233		64,233			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,850	301,075	402,925		402,925		402,925			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,812,149	585,993	2,776,899	6,175,041		6,175,041	(393,844)	5,781,197			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-04**

Ending: **31-Dec-04**

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	(13,347)	30		9
10	Interest and Other Investment Income	(643)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(293)	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	(62,954)	21		24
25	Fund Raising, Advertising and Promotional	(37,131)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,000)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(288)	20		28
29	Other-Attach Schedule **Per Page 5A attached	(7,095)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (125,751)		\$	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)	(268,093)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (268,093)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (393,844)		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-04

Ending: 31-Dec-04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance Costs (expended in 2004)	\$ (8,515)	6	1
2	Deferred Maintenance Costs (to write off in 2004)	1,420	6	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	(7,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04**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	(293)	0	0	0	0	0	0	0	0	0	0	(293)	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	(7,095)	0	0	0	0	0	0	0	0	0	0	(7,095)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,388)	0	0	0	0	0	0	0	0	0	0	(7,388)	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	(131,414)	0	0	0	0	0	0	0	0	0	(131,414)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,051	885	0	0	0	0	0	0	0	0	4,936	19
20	Fees, Subscriptions & Promotions	(37,419)	16,194	0	0	0	0	0	0	0	0	0	(21,225)	20
21	Clerical & General Office Expenses	(66,954)	68,081	4,000	0	0	0	0	0	0	0	0	5,127	21
22	Employee Benefits & Payroll Taxes	0	32,683	0	0	0	0	0	0	0	0	0	32,683	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,159	0	0	0	0	0	0	0	0	0	4,159	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	8,681	0	0	0	0	0	0	0	0	0	8,681	27
28	TOTAL General Administration	(104,373)	2,435	4,885	0	(97,053)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,761)	2,435	4,885	0	(104,441)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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	(13,347)	454	0	0	0	0	0	0	0	0	0	(12,893) 30
31	Amortization of Pre-Op. & Org.	0	0	2,901	0	0	0	0	0	0	0	0	2,901 31
32	Interest	(643)	17,255	474,737	0	0	0	0	0	0	0	0	491,349 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	(13,990)	17,709	(293,122)	0	(289,403) 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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(125,751)	20,144	(288,237)	0	(393,844) 45							

Facility Name & ID Number **Wauconda Healthcare and Rehabilitation**# **0044859**

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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 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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 56,123	\$ 56,123	1
2	V	27 Payroll Taxes-Officers'		Lancaster, Ltd.	100.00%	2,571	2,571	2
3	V	17 Management Fee Income	203,580	Lancaster, Ltd.	100.00%		(203,580)	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	4,051	4,051	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	68,081	68,081	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	32,683	32,683	6
7	V	24 Education, Seminars & Travel		Lancaster, Ltd.	100.00%	4,159	4,159	7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	16,043	16,043	8
9	V	20 Fees and Marketing		Lancaster, Ltd.	100.00%	16,194	16,194	9
10	V	32 Interest		Lancaster, Ltd.	100.00%	17,255	17,255	10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	454	454	11
12	V	27 Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	6,110	6,110	12
13	V							13
14	Total		\$ 203,580			\$ 223,724	\$ * 20,144	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rental	\$ 1,200,000	Wauconda Associates	100.00%	\$ 429,240	\$ (770,760)
16	V	32 Interest	5,263	Wauconda Associates	100.00%	480,000	474,737
17	V	31 Amortization		Wauconda Associates	100.00%	2,901	2,901
18	V	21 Illinois Replacement Tax		Wauconda Associates	100.00%	4,000	4,000
19	V	19 Accounting Fee		Wauconda Associates	100.00%	885	885
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		\$ 1,205,263			\$ 917,026	\$ * (288,237)

* 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-04 Ending: 31-Dec-04

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	5	10.42%	Lancaster	\$ 23,302	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	see attached	5	10.42%	Lancaster	16,434	17-7	2
3	Cheryl Morris	VP-Operation	Administrative	0.00	see attached	5	10.42%	Lancaster	16,387	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,123		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-04 Ending: 1-Dec-04

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) 604.4416
 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	\$ 223,698	5	\$ 23,302	1	
2	27	Laurence Zung	Hours Worked	48	7	8,867	5	924	2	
3	17	Christopher Vicere	Hours Worked	48	7	157,762	5	16,434	3	
4	27	Christopher Vicere	Hours Worked	48	7	7,911	5	824	4	
5	17	Cheryl Morris	Hours Worked	48	7	157,315	5	16,387	5	
6	27	Cheryl Morris	Hours Worked	48	7	7,905	5	823	6	
7									7	
8									8	
9	19	Professional Services	Management Fees	2,360,020	7	46,963	203,580	4,051	9	
10	21	Clerical Expenses	Management Fees	2,360,020	7	62,820	203,580	5,419	10	
11	22	Employee Benefits	Management Fees	2,360,020	7	378,883	203,580	32,683	11	
12	24	Education and Seminars	Management Fees	2,360,020	7	8,842	203,580	763	12	
13	17	Administrative Consultant	Management Fees	2,360,020	7	185,978	185,978	203,580	16,043	13
14	20	Marketing	Management Fees	2,360,020	7	171,696	155,227	203,580	14,811	14
15	32	Interest	Management Fees	2,360,020	7	131,563	203,580	11,349	15	
16	30	Depreciation	Management Fees	2,360,020	7	5,260	203,580	454	16	
17	20	Licenses and Fees	Management Fees	2,360,020	7	16,029	203,580	1,383	17	
18	24	Travel	Management Fees	2,360,020	7	39,372	203,580	3,396	18	
19	21	Salaries-Clerical	Management Fees	2,360,020	7	726,412	726,412	203,580	62,662	19
20	27	Payroll Taxes-Clerical	Management Fees	2,360,020	7	70,836	203,580	6,110	20	
21									21	
22									22	
23	32	Direct Interest						5,906	23	
24									24	
25	TOTALS					\$ 2,408,113	\$ 1,606,392	\$ 223,724	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					11,349	6										
7	Harston Investments		X	Working Capital					480,000	7										
8										8										
9	TOTAL Facility Related				\$	\$			\$ 491,349	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related				\$	\$			\$	14										
15	TOTALS (line 9+line14)				\$	\$			\$ 491,349	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 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 2003 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 2003.

(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>51,822.06</u>	\$ <u>51,822.06</u>
2. <u>09-35-200-059</u>	<u>Long-Term HealthCare</u>	\$ <u>6,493.11</u>	\$ <u>6,493.11</u>
3. <u>09-35-200-057</u>	<u>Long-Term HealthCare</u>	\$ <u>213.52</u>	\$ <u>213.52</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>58,528.69</u>	\$ <u>58,528.69</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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859 Report Period Beginning:1-Jan-04 Ending:31-Dec-04

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-04

Ending:

31-Dec-04

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	203	20	203		1,031	9
10	Nurses' Call System		2001		18,785	1,848	20	2,641	793	12,184	10
11	Fire Protection System		2001		99,420	9,783	20	13,975	4,192	64,482	11
12	Nurse Call Additions		2002		1,100	135	20	73	(62)	170	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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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	\$ 11,969		\$ 16,892	\$ 4,923	\$ 77,867		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	\$ 134,025	\$ 18,970	\$ 20,143	\$ 1,173	10	\$ 80,929	71
72	Current Year Purchases	38,592	23,156	3,713	(19,443)	10	3,713	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 172,617	\$ 42,126	\$ 23,856	\$ (18,270)		\$ 84,642	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)	\$ 294,784	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,095	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,748	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,347)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 162,509	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 Original Lease Date	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>12/31/2005</u>	\$ <u>429,240</u>
13.	<u>12/31/2006</u>	\$ <u>462,029</u>
14.	<u>12/31/2007</u>	\$ <u>465,010</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: \$ 12,409 Description: Laundry Washer \$1509(@215.57 p.m.X 7 Months) & Copier \$10,900 (@ 908.34 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><u>N/A</u></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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	52,537	\$		\$	52,537	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs				8,978				8,978	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39-3	hrs				175,327				175,327	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39-2	# of prescripts						92,978		92,978	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify): **Medical Supplies** **Specialty Beds**	39-2 39-2							5,174 3,698		5,174 3,698	13		
14	TOTAL			\$		\$	236,842	\$	101,850	\$	338,692	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-04

Ending:

31-Dec-04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-04

(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	\$ 1,063	\$ 1,063	1
2 Cash-Patient Deposits	51,108	51,108	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,361,642	1,361,642	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	28,374	28,374	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	2,448	2,448	8
9 Other(specify): *Refundable Deposits*	1,175	1,175	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,445,810	\$ 1,445,810	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	172,616	172,616	16
17 Accumulated Depreciation (book methods)	(223,599)	(223,599)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		14,507	19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(13,540)	20
21 Restricted Funds			21
22 Other Long-Term Assets (spe *Option Deposit*)		3,600,000	22
23 Other(specify): *Construction-in-Progress*	57,200	1,464,153	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 128,384	\$ 5,136,304	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,574,194	\$ 6,582,114	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 156,745	\$ 156,745	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	51,108	51,108	28
29 Short-Term Notes Payable	289,976	839,598	29
30 Accrued Salaries Payable	252,460	252,460	30
31 Accrued Taxes Payable (excluding real estate taxes)	10,935	10,935	31
32 Accrued Real Estate Taxes(Sch.IX-B)	58,800	58,800	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)	\$ 820,024	\$ 1,369,646	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)	\$ 820,024	\$ 5,369,646	46
47 TOTAL EQUITY(page 18, line 24)	\$ 754,170	\$ 1,212,468	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,574,194	\$ 6,582,114	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 979,628	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 979,628	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	274,542	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	(500,000)	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)	\$ (225,458)	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)	\$ 754,170	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	\$ 1,149,689	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,149,689	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	562,779	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	(500,000)	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)	\$ 62,779	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)	\$ 1,212,468	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning: 1-Jan-04

Ending:

31-Dec-04

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	\$ 6,686,721	1
2	Discounts and Allowances for all Levels	(1,028,662)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,658,059	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	564,261	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 564,261	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,192	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	202,559	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,839	19
20	Radiology and X-Ray	1,911	20
21	Other Medical Services	7,119	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 226,620	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	643	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 643	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)	\$ 6,449,583	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,088,381	31
32	Health Care	2,209,915	32
33	General Administration	1,148,141	33
B. Capital Expense			
34	Ownership	1,325,679	34
C. Ancillary Expense			
35	Special Cost Centers	338,692	35
36	Provider Participation Fee	64,233	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,175,041	40
41	Income before Income Taxes (line 30 minus line 40)**	274,542	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 274,542	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-04**Ending: **31-Dec-04**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,141	2,304	\$ 76,347	\$ 33.14	1
2	Assistant Director of Nursing	1,473	1,586	41,993	26.48	2
3	Registered Nurses	25,535	27,349	702,930	25.70	3
4	Licensed Practical Nurses	4,400	4,851	117,563	24.23	4
5	Nurse Aides & Orderlies	70,778	76,303	948,521	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	303	311	4,261	13.70	9
10	Activity Assistants	4,386	4,789	43,017	8.98	10
11	Social Service Workers	3,096	3,358	40,238	11.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,611	25,900	256,250	9.89	15
16	Dishwashers					16
17	Maintenance Workers	1,898	2,026	33,598	16.58	17
18	Housekeepers	25,299	27,293	219,524	8.04	18
19	Laundry	4,084	4,219	36,704	8.70	19
20	Administrator	1,904	2,155	89,674	41.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,084	12,041	171,790	14.27	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	2,148	2,276	29,739	13.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,140	196,761	\$ 2,812,149 *	\$ 14.29	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	270	\$ 10,276	1-3	35
36	Medical Director	234	8,400	9-3	36
37	Medical Records Consultant	109	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	103	2,987	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	2,160	12-3	45
46	Other(specify) **Dementia**	30	975	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	806	\$ 28,926		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,568	\$ 71,130	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,568	\$ 71,130		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lenette Clark (through May'04)	Administrator	N/A	\$ 36,808	Workers' Compensation Insurance	\$ 36,203	IDPH License Fee	\$ 1,085	
James Farlee (effective Jun'04)	Administrator	N/A	52,866	Unemployment Compensation Insurance	23,649	Advertising: Employee Recruitment	2,223	
				FICA Taxes	207,431	Health Care Worker Background Check	1,100	
				Employee Health Insurance	124,611	(Indicate # of checks performed <u>92</u>)		
				Employee Meals	11,873	***Advertising & Promotions***	22,230	
				Illinois Municipal Retirement Fund (IMRF)*		***Licenses and Fees***	4,670	
				Misc. Employee Benefits	10,885	***Dues and Subscriptions***	1,142	
				Retirement Plan Contributions	9,314	***Advertising Yellow Pages***	288	
				Employment Fees	31,561	***Lancaster Allocation***	16,194	
				Lancaster Allocation	32,683			
						Less: Public Relations Expense	(14,811)	
						Non-allowable advertising	(22,320)	
						Yellow page advertising	(288)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,674	TOTAL (agree to Schedule V, line 22, col.8)	\$ 488,210	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,513	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Lancaster, Ltd.			\$ 203,580				Out-of-State Travel	\$
							In-State Travel	1,435
							Lancaster Allocation	3,396
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 203,580				Seminar Expense	6,798
							Lancaster Allocation	763
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	\$ 12,392
Accu-Med Services Inc.	Data Processing		\$ 1,350					
AMA Dept. of Data Services	Data Processing		600					
Health Data Systems	Data Processing		5,013					
Personnel Planners	Unemployment Tax Consult.		645					
Richard Peelo	Accounting		2,250					
Frost Ruttenger & Rothblatt	Accounting		1,325					
Richard Nakon	Legal		895					
Stone, Pogrud & Korey	Legal		58,044					
Yalden, Olsen & Willette	Legal		324					
Law Office of LMDBLT	Legal		150					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 70,596	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting & Decorating	Mar-2004	\$ 1,000	3	\$	\$	\$	\$ 167	\$ 333	\$ 333	\$ 167	\$
2	Painting & Decorating	Apr-2004	2,000	3				333	667	667	333	
3	Painting & Decorating	Apr-2004	5,515	3				920	1,838	1,837	920	
4												
5												
6												
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17												
18												
19												
20	TOTALS		\$ 8,515		\$	\$	\$	\$ 1,420	\$ 2,838	\$ 2,837	\$ 1,420	\$

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859Report Period Beginning: 1-Jan-04Ending: 31-Dec-04**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? No
If YES, give association name and amount. N/A
- (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. \$ 16,166 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 64,233
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. \$ 11,873 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.