

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0044859

Facility Name: Wauconda Healthcare and Rehabilitation

Address: 176 Thomas Court Wauconda 60084
 Number City Zip Code

County: Lake

Telephone Number: (847) 526-5551 **Fax #** (847) 526-0807

HFS ID Number: 36-4343848

Date of Initial License for Current Owners: 1st May 2000

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2006 to 31-Dec-2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	<u>29th March 2007</u>
	(Type or Print Name) <u>Christopher Vicere</u>	(Date)
Paid Preparer	(Title) <u>Vice President - Finance</u>	
	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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>125</u>	Skilled (SNF)	<u>125</u>	<u>45,625</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>125</u>	TOTALS	<u>125</u>	<u>45,625</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,844</u>	<u>3,495</u>	<u>6,766</u>	<u>14,105</u>	8
9	SNF/PED					9
10	ICF	<u>24,203</u>	<u>4,405</u>	<u>283</u>	<u>28,891</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,047</u>	<u>7,900</u>	<u>7,049</u>	<u>42,996</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.24%

D. How many bed-hold days during this year were paid by the Department?

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

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

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

NoneF. 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 1st May 2000

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

YES Date 1st May 2000 NO

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

YES NO If YES, enter number of beds certified 125 and days of care provided 6,505Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	313,969	38,860	10,049	362,878		362,878		362,878		1
2	Food Purchase		251,976		251,976	(13,650)	238,326	(447)	237,879		2
3	Housekeeping	268,507	56,873		325,380		325,380		325,380		3
4	Laundry	38,978	40,758		79,736		79,736		79,736		4
5	Heat and Other Utilities			191,388	191,388		191,388		191,388		5
6	Maintenance	51,706	59,353	100,891	211,950		211,950	(1,858)	210,092		6
7	Other (specify):*										7
8	TOTAL General Services	673,160	447,820	302,328	1,423,308	(13,650)	1,409,658	(2,305)	1,407,353		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	2,674,885	186,114	131,485	2,992,484		2,992,484		2,992,484		10
10a	Therapy			1,715	1,715		1,715		1,715		10a
11	Activities	108,057	42,045	1,207	151,309		151,309		151,309		11
12	Social Services	77,152		2,120	79,272		79,272		79,272		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,860,094	228,159	144,927	3,233,180		3,233,180		3,233,180		16
	C. General Administration										
17	Administrative	65,718		199,500	265,218		265,218	(114,375)	150,843		17
18	Directors Fees										18
19	Professional Services			33,771	33,771		33,771	11,299	45,070		19
20	Dues, Fees, Subscriptions & Promotions			55,127	55,127		55,127	(42,569)	12,558		20
21	Clerical & General Office Expenses	185,383	87,642	46,181	319,206		319,206	22,750	341,956		21
22	Employee Benefits & Payroll Taxes			623,967	623,967	13,650	637,617	6,882	644,499		22
23	Inservice Training & Education			3,371	3,371		3,371	1,585	4,956		23
24	Travel and Seminar			4,334	4,334		4,334	2,565	6,899		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			238,446	238,446		238,446		238,446		26
27	Other (specify):* *Payroll Taxes (Sch VII)							14,152	14,152		27
28	TOTAL General Administration	251,101	87,642	1,204,697	1,543,440	13,650	1,557,090	(97,711)	1,459,379		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,784,355	763,621	1,651,952	6,199,928		6,199,928	(100,016)	6,099,912		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.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Wauconda Healthcare and Rehabilitation #0044859 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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			38,169	38,169		38,169	105,940	144,109			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,823	78,823		78,823	401,988	480,811			32
33	Real Estate Taxes			60,647	60,647		60,647		60,647			33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(737,971)	462,029			34
35	Rent-Equipment & Vehicles			11,684	11,684		11,684		11,684			35
36	Other (specify):*											36
37	TOTAL Ownership			1,389,323	1,389,323		1,389,323	(230,043)	1,159,280			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,911	505,202	774,113		774,113		774,113			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,438	68,438		68,438		68,438			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		268,911	573,640	842,551		842,551		842,551			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,784,355	1,032,532	3,614,915	8,431,802		8,431,802	(330,059)	8,101,743			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-2006

Ending: 31-Dec-2006

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	14,925	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	(447)	2		13
14	Non-Care Related Interest	(43,125)	32		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	(794)	24		19
20	Contributions	(150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,896)	21		24
25	Fund Raising, Advertising and Promotional	(63,520)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,009)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule ** Page 5A attached **	(1,858)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,874)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(212,185)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (212,185)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (330,059)		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

BHF USE ONLY					
48		49		50	51
					52

Wauconda Healthcare and Rehabilitation

ID# 0044859

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance Costs (expended in 2006)	\$ (6,246)	6	1
2	Deferred Maintenance Costs (to write off in 2006)	4,388	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	(1,858)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	(447)	0	0	0	0	0	0	0	0	0	0	(447)	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	(1,858)	0	0	0	0	0	0	0	0	0	0	(1,858)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,305)	0	0	0	0	0	0	0	0	0	0	(2,305)	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	CNA 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	(114,375)	0	0	0	0	0	0	0	0	0	(114,375)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,264	1,035	0	0	0	0	0	0	0	0	11,299	19
20	Fees, Subscriptions & Promotions	(63,670)	21,101	0	0	0	0	0	0	0	0	0	(42,569)	20
21	Clerical & General Office Expenses	(22,905)	43,646	2,009	0	0	0	0	0	0	0	0	22,750	21
22	Employee Benefits & Payroll Taxes	0	6,882	0	0	0	0	0	0	0	0	0	6,882	22
23	Inservice Training & Education	0	1,585	0	0	0	0	0	0	0	0	0	1,585	23
24	Travel and Seminar	(794)	3,359	0	0	0	0	0	0	0	0	0	2,565	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	14,152	0	0	0	0	0	0	0	0	0	14,152	27
28	TOTAL General Administration	(87,369)	(13,386)	3,044	0	(97,711)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(89,674)	(13,386)	3,044	0	(100,016)	29							

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning:

1-Jan-2006 Ending:

Summary B

31-Dec-2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	14,925	486	90,529	0	0	0	0	0	0	0	0	105,940	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43,125)	(68,929)	514,042	0	0	0	0	0	0	0	0	401,988	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(737,971)	0	0	0	0	0	0	0	0	(737,971)	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	(28,200)	(68,443)	(133,400)	0	(230,043)	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)	(117,874)	(81,829)	(130,356)	0	(330,059)	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 Management Fee Income	\$ 199,500	Lancaster, Ltd.	100.00%	\$	\$ (199,500) 1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	36,999	36,999 2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	10,264	10,264 3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	43,646	43,646 4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	6,882	6,882 5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	3,359	3,359 6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	48,126	48,126 7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	20,654	20,654 8
9	V	32 Interest	69,740	Lancaster, Ltd.	100.00%	811	(68,929) 9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	486	486 10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	447	447 11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	14,152	14,152 12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	1,585	1,585 13
14	Total		\$ 269,240			\$ 187,411	\$ * (81,829) 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-2006 Ending: 31-Dec-2006

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%	\$ 462,029	\$ (737,971)	15
16	V	32 Interest		Wauconda Associates	100.00%	514,042	514,042	16
17	V	30 Depreciation		Wauconda Associates	100.00%	90,529	90,529	17
18	V	21 Illinois Replacement Tax		Wauconda Associates	100.00%	2,009	2,009	18
19	V	19 Accounting Fees		Wauconda Associates	100.00%	1,035	1,035	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,200,000			\$ 1,069,644	\$ * (130,356)	39

* 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-2006 Ending: 31-Dec-2006

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	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 18,521	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	18,478	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,999		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-2006 Ending: -Dec-2006

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	5	\$ 18,521	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,454		5	985	2
3	17	Cheryl Morris	Hours Worked	48	7	177,385	177,385	5	18,478	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,436		5	983	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		199,500	10,264	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	199,500	43,646	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		199,500	6,882	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		199,500	3,359	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	199,500	48,126	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	199,500	20,654	18
19	32	Interest	Management Fees	2,146,620	7	8,729		199,500	811	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		199,500	486	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		199,500	447	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		199,500	12,184	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		199,500	1,585	23
24	32	*Direct Interest*								24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 187,411	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	JP Morgan Chase Bank		X	Working Capital						811	6									
7	Harston Investments		X	Working Capital						480,000	7									
8											8									
9	TOTAL Facility Related									480,811	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									480,811	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 59,000	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.)		\$ 58,647	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (353)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 61,000	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.		\$ 60,647	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	<u>59,283</u>	<u>8</u>
	2002	<u>56,766</u>	<u>9</u>
	2003	<u>58,529</u>	<u>10</u>
	2004	<u>56,130</u>	<u>11</u>
	2005	<u>58,647</u>	<u>12</u>
Accrual is based on average of last 4 year's taxes adjusted for inflation			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>51,900.24</u>	\$ <u>51,900.24</u>
2. <u>09-35-200-059</u>	<u>Long-Term HealthCare</u>	\$ <u>6,544.75</u>	\$ <u>6,544.75</u>
3. <u>09-35-200-057</u>	<u>Long-Term HealthCare</u>	\$ <u>202.45</u>	\$ <u>202.45</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>58,647.44</u>	\$ <u>58,647.44</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

****N/A****

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Redwood Sign 4x6		2000	2,862	169	15	169		1,384	9
10		Nurses' Call System		2001	18,785	1,148	7	1,640	492	15,710	10
11		Fire Protection System		2001	99,420	6,076	7	8,680	2,604	83,145	11
12		Nurse Call Additions		2002	1,100	69	7	74	5	318	12
13		Construction of Dementia Unit		2006	2,288,579	31,834	40	66,750	34,916	66,750	13
14		Fittings & Fixtures to Dementia Unit		2006	130,960	26,192	5	15,279	(10,913)	15,279	14
15		Concrete Sidewalk		2006	7,050	353	15	274	(79)	274	15
16		Outside Landscaping		2006	19,800	990	15	770	(220)	770	16
17		New Brick Patio		2006	7,400	246	15	61	(185)	61	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	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)	\$ 2,575,956	\$ 67,077		\$ 93,697	\$ 26,620	\$ 183,691	70

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	\$ 145,602	\$ 19,941	\$ 26,860	\$ 6,919	5	\$ 78,893	71
72	Current Year Purchases	209,158	40,540	21,926	(18,614)	5	21,926	72
73	Fully Depreciated Assets	62,761	1,140	1,140		5	62,761	73
74			486	486		5	2,462	74
75	TOTALS	\$ 417,521	\$ 62,107	\$ 50,412	\$ (11,695)		\$ 166,042	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)	\$ 2,993,477	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,184	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,109	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,925	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 349,733	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.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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:				\$			3
4	Additions				462,029			4
5								5
6								6
7	TOTAL				\$ 462,029			7

10. Effective dates of current rental agreement:

Beginning 1-May-2000

Ending 30-Apr-2007

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>12/31/2006</u>	\$ <u>462,029</u>
13.	<u>12/31/2007</u>	\$ <u>465,010</u>
14.		\$

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: \$ 11,684

Description: Copier @\$953.76 for 7 months & @\$1,001.45 for 5 months

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-3	hrs	\$		\$ 212,109	\$		\$ 212,109	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,543			88,543	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			204,550			204,550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs							8
9	Pharmacy	39-2	# of prescrpts				183,432		183,432	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** **Speciality Beds**	39-2 39-2					46,853 38,626		46,853 38,626	13
14	TOTAL			\$		\$ 505,202	\$ 268,911		\$ 774,113	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859Report Period Beginning: 1-Jan-2006

Ending:

31-Dec-2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 31-Dec-2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 900	\$ 900	1
2	Cash-Patient Deposits	38,693	38,693	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,213,586	2,213,586	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,885	43,885	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,300	1,300	8
9	Other(specify): <u>Refundable Security Deposit</u>	1,540	1,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,299,904	\$ 2,299,904	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	129,567	2,575,957	15
16	Equipment, at Historical Cost	261,716	417,520	16
17	Accumulated Depreciation (book methods)	(296,732)	(387,261)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,507)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe *Option Deposit*		3,600,000	22
23	Other(specify): **Construction-in-Progress**		232,940	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 94,551	\$ 6,439,156	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,394,455	\$ 8,739,060	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 184,702	\$ 184,702	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,693	38,693	28
29	Short-Term Notes Payable	1,222,844	1,981,382	29
30	Accrued Salaries Payable	353,464	353,464	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,294	16,294	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,000	61,000	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)	\$ 1,877,997	\$ 2,635,535	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)	\$ 1,877,997	\$ 6,635,535	46
47	TOTAL EQUITY(page 18, line 24)	\$ 517,458	\$ 2,103,525	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,395,455	\$ 8,739,060	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 673,701	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 673,701	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(156,243)	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)	\$ (156,243)	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)	\$ 517,458	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	\$ 1,379,412	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,379,412	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,887)	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) ** Shareholder's Loan **	750,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 724,113	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)	\$ 2,103,525	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859Report Period Beginning: 1-Jan-2006Ending: 31-Dec-2006**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	\$ 8,292,827	1
2	Discounts and Allowances for all Levels	(1,921,040)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,371,787	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,497,737	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,497,737	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	339,568	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,909	19
20	Radiology and X-Ray	2,435	20
21	Other Medical Services	56,123	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 406,035	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)	\$ 8,275,559	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,423,308	31
32	Health Care	3,233,180	32
33	General Administration	1,543,440	33
B. Capital Expense			
34	Ownership	1,389,323	34
C. Ancillary Expense			
35	Special Cost Centers	774,113	35
36	Provider Participation Fee	68,438	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,431,802	40
41	Income before Income Taxes (line 30 minus line 40)**	(156,243)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (156,243)	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-2006

Ending:

31-Dec-2006

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	1,291	1,433	\$ 50,271	\$ 35.08	1
2	Assistant Director of Nursing	1,187	1,234	28,906	23.42	2
3	Registered Nurses	36,167	39,276	1,000,979	25.49	3
4	Licensed Practical Nurses	7,073	7,679	169,606	22.09	4
5	CNAs & Orderlies	103,465	110,066	1,391,916	12.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,889	2,054	29,172	14.20	9
10	Activity Assistants	6,267	6,700	78,885	11.77	10
11	Social Service Workers	4,454	5,171	77,152	14.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,919	32,293	313,969	9.72	15
16	Dishwashers					16
17	Maintenance Workers	4,132	4,411	51,706	11.72	17
18	Housekeepers	31,309	33,057	268,507	8.12	18
19	Laundry	4,015	4,338	38,978	8.99	19
20	Administrator	1,901	2,039	65,718	32.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,114	12,085	185,383	15.34	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	1,811	2,062	33,207	16.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,994	263,898	\$ 3,784,355 *	\$ 14.34	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	287	\$ 10,049	1-3	35
36	Medical Director	234	8,400	9-3	36
37	Medical Records Consultant	114	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	203	5,892	10-3	39
40	Physical Therapy Consultant	49	1,715	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,207	11-3	44
45	Social Service Consultant	64	2,120	12-3	45
46	Other(specify) <u>**Dementia**</u>	120	3,971	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,119	\$ 37,578		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,330	\$ 110,035	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	353	7,363	10-3	52
53	TOTAL (lines 50 - 52)	4,683	\$ 117,398		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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	Painting & Decorating	Sep-2005	1,532	3			256	510	510	256			
5	Painting & Decorating	Jul-2006	6,246	3				1,041	2,082	2,082	1,041		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 16,293		\$	\$ 1,420	\$ 3,094	\$ 4,388	\$ 4,012	\$ 2,338	\$ 1,041	\$	

