



Facility Name & ID Number Wauconda Healthcare and Rehab

# 0044859 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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>4,070</u>	<u>6,169</u>	<u>8,378</u>	<u>18,617</u>	8
9	SNF/PED					9
10	ICF	<u>19,271</u>	<u>3,494</u>		<u>22,765</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,341</u>	<u>9,663</u>	<u>8,378</u>	<u>41,382</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

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

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

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

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

None

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

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

YES  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 7,951

Medicare 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 2007 Fiscal Year: 31st Dec 2007

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

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	325,823	44,199	9,694	379,716		379,716	379,716			1
2	Food Purchase		288,363		288,363	(14,741)	273,622	(648)	272,974		2
3	Housekeeping	324,328	82,394		406,722		406,722	406,722			3
4	Laundry	44,747	31,053		75,800		75,800	75,800			4
5	Heat and Other Utilities			223,247	223,247		223,247	223,247			5
6	Maintenance	64,713	104,157	141,738	310,608		310,608	(1,358)	309,250		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	759,611	550,166	374,679	1,684,456	(14,741)	1,669,715	(2,006)	1,667,709		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,400	11,400		11,400	11,400			9
10	Nursing and Medical Records	2,950,246	177,128	38,392	3,165,766		3,165,766	3,165,766			10
10a	Therapy		10,370	1,844	12,214		12,214	12,214			10a
11	Activities	97,616	35,387		133,003		133,003	133,003			11
12	Social Services	70,896		1,623	72,519		72,519	72,519			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,118,758	222,885	53,259	3,394,902		3,394,902	3,394,902			16
	<b>C. General Administration</b>										
17	Administrative	59,477		157,500	216,977		216,977	(64,884)	152,093		17
18	Directors Fees										18
19	Professional Services			35,019	35,019		35,019	5,447	40,466		19
20	Dues, Fees, Subscriptions & Promotions			39,747	39,747		39,747	(23,254)	16,493		20
21	Clerical & General Office Expenses	197,113	51,027	24,317	272,457		272,457	47,579	320,036		21
22	Employee Benefits & Payroll Taxes			581,117	581,117	14,741	595,858	14,366	610,224		22
23	Inservice Training & Education			16,169	16,169		16,169	1,140	17,309		23
24	Travel and Seminar			2,398	2,398		2,398	2,358	4,756		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			8,303	8,303		8,303		8,303		26
27	Other (specify):* <b>*Payroll Taxes (Sch VII)</b>							12,060	12,060		27
28	<b>TOTAL General Administration</b>	256,590	51,027	864,570	1,172,187	14,741	1,186,928	(5,188)	1,181,740		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,134,959	824,078	1,292,508	6,251,545		6,251,545	(7,194)	6,244,351		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 Rehab

#0044859

Report Period Beginning: 1-Jan-2007 Ending:

31-Dec-2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			49,641	49,641		49,641	192,032	241,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,951	42,951		42,951	525,488	568,439			32
33	Real Estate Taxes			77,774	77,774		77,774		77,774			33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(734,990)	465,010			34
35	Rent-Equipment & Vehicles			7,010	7,010		7,010		7,010			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,377,376	1,377,376		1,377,376	(17,470)	1,359,906			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		306,012	624,805	930,817		930,817		930,817			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	<b>TOTAL Special Cost Centers</b>		306,012	693,243	999,255		999,255		999,255			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,134,959	1,130,090	3,363,127	8,628,176		8,628,176	(24,664)	8,603,512			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 Rehab

# 0044859

Report Period Beginning: 1-Jan-2007

Ending: 31-Dec-2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,327	30		9
10	Interest and Other Investment Income	(3,822)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(648)	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	(669)	24		19
20	Contributions	(90)	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	(969)	21		24
25	Fund Raising, Advertising and Promotional	(47,238)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(258)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(274)	20		28
29	Other-Attach Schedule	(1,358)	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (37,999)		\$	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)	13,335	pg 6 & 6A	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 13,335		36
(sum of SUBTOTALS				
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (24,664)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Wauconda Healthcare and Rehab

ID# 0044859

Report Period Beginning: 1-Jan-2007

Ending: 31-Dec-2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance Costs (expended in 2007)	\$ (6,440)	6	1
2	Deferred Maintenance Costs (to write off in 2007)	5,082	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	<b>Total</b>	(1,358)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehab# 0044859

Report Period Beginning:

1-Jan-2007

Ending:

31-Dec-2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(648)	0	0	0	0	0	0	0	0	0	0	(648)	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	(1,358)	0	0	0	0	0	0	0	0	0	0	(1,358)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,006)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,006)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(64,884)	0	0	0	0	0	0	0	0	0	(64,884)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,482	965	0	0	0	0	0	0	0	0	5,447	19
20	Fees, Subscriptions & Promotions	(47,602)	24,348	0	0	0	0	0	0	0	0	0	(23,254)	20
21	Clerical & General Office Expenses	(1,227)	48,548	258	0	0	0	0	0	0	0	0	47,579	21
22	Employee Benefits & Payroll Taxes	0	14,366	0	0	0	0	0	0	0	0	0	14,366	22
23	Inservice Training & Education	0	1,140	0	0	0	0	0	0	0	0	0	1,140	23
24	Travel and Seminar	(669)	3,027	0	0	0	0	0	0	0	0	0	2,358	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	12,060	0	0	0	0	0	0	0	0	0	12,060	27
28	<b>TOTAL General Administration</b>	<b>(49,498)</b>	<b>43,087</b>	<b>1,223</b>	<b>0</b>	<b>(5,188)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(51,504)</b>	<b>43,087</b>	<b>1,223</b>	<b>0</b>	<b>(7,194)</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehab

# 0044859

Report Period Beginning:

1-Jan-2007 Ending:

Summary B

31-Dec-2007

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	17,327	567	174,138	0	0	0	0	0	0	0	0	192,032	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,822)	(85,668)	614,978	0	0	0	0	0	0	0	0	525,488	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(734,990)	0	0	0	0	0	0	0	0	(734,990)	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	<b>TOTAL Ownership</b>	<b>13,505</b>	<b>(85,101)</b>	<b>54,126</b>	<b>0</b>	<b>(17,470)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(37,999)</b>	<b>(42,014)</b>	<b>55,349</b>	<b>0</b>	<b>(24,664)</b>	<b>45</b>							

**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	\$ 157,500	Lancaster, Ltd.	100.00%	\$	\$ (157,500)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	40,954	40,954	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	4,482	4,482	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	48,548	48,548	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	14,366	14,366	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	3,027	3,027	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	51,662	51,662	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	23,680	23,680	8
9	V	32 Interest	87,929	Lancaster, Ltd.	100.00%	2,261	(85,668)	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	567	567	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	668	668	11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	12,060	12,060	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	1,140	1,140	13
14	Total		\$ 245,429			\$ 203,415	\$ * (42,014)	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		\$ 465,010	\$ (734,990)	15
16	V	32	Interest		Wauconda Associates		614,978	614,978	16
17	V	30	Depreciation		Wauconda Associates		174,138	174,138	17
18	V	21	Illinois Replacement Tax		Wauconda Associates		258	258	18
19	V	19	Accounting Fees		Wauconda Associates		965	965	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				\$ 1,255,349	\$ * 55,349	39

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

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

## 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	\$ 20,477	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	20,477	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	\$ 40,954		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 Rehab

# 0044859

Report Period Beginning:

1-Jan-2007

Ending: -Dec-2007

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	\$ 196,583	\$ 196,583	5	\$ 20,477	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,894		5	1,031	2
3	17	Cheryl Morris	Hours Worked	48	7	196,583	196,583	5	20,477	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,894		5	1,031	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	1,694,700	7	48,231		157,500	4,482	13
14	21	Clerical Expenses	Management Fees	1,694,700	7	522,379	452,822	157,500	48,548	14
15	22	Employee Benefits	Management Fees	1,694,700	7	154,573		157,500	14,366	15
16	24	Seminars & Travel	Management Fees	1,694,700	7	32,569		157,500	3,027	16
17	17	Administrative Consulting	Management Fees	1,694,700	7	555,885	555,885	157,500	51,662	17
18	20	Marketing and Fees	Management Fees	1,694,700	7	254,796	183,072	157,500	23,680	18
19	32	Interest	Management Fees	1,694,700	7	24,333		157,500	2,261	19
20	30	Depreciation	Management Fees	1,694,700	7	6,106		157,500	567	20
21	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	7,190		157,500	668	21
22	27	Payroll Taxes	Management Fees	1,694,700	7	107,574		157,500	9,998	22
23	23	Education & Inservice	Management Fees	1,694,700	7	12,265		157,500	1,140	23
24	32	*Direct Interest*							(87,929)	24
25	TOTALS					\$ 2,138,857	\$ 1,584,945		\$ 115,486	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	JP Morgan Chase Bank		X	Working Capital						2,261	6									
7	Harston Investments		X	Working Capital						570,000	7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$		\$ 572,261	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$ 572,261	15									

Less: Interest Income (3,822)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A 568,439

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

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

Facility Name & ID Number Wauconda Healthcare and Rehab# 0044859 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2006 report.			\$	61,000	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.)			\$	68,274	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	7,274	3																			
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	70,500	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	77,774	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:																									
	2002	56,766	8	<table border="1"> <tr> <td colspan="3"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																									
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2003	58,529	9																						
	2004	56,130	10																						
	2005	58,647	11																						
	2006	68,274	12																						
<b>**Accrual is based on weighted average of last 4 year's taxes; adjusted for inflation**</b>																									
<b>** More weightage is placed on 2006 taxes due to new construction**</b>																									

## NOTES:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Wauconda Healthcare and Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

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 2006 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 2006.

(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>61,624.37</u>	\$ <u>61,624.37</u>
2. <u>09-35-200-059</u>	<u>Long-Term HealthCare</u>	\$ <u>6,449.73</u>	\$ <u>6,449.73</u>
3. <u>09-35-200-057</u>	<u>Long-Term HealthCare</u>	\$ <u>199.49</u>	\$ <u>199.49</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>68,273.59</u>	\$ <u>68,273.59</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        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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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
	<b>Improvement Type**</b>										
9		Redwood Sign 4x6		2000	2,862	169	15	169		1,553	9
10		Nurses' Call System		2001	18,785	1,148	7	1,640	492	17,350	10
11		Fire Protection System		2001	99,420	6,076	7	8,680	2,604	91,825	11
12		Nurse Call Additions		2002	1,100	69	7	73	4	391	12
13		Construction of Dementia Unit		2006	2,288,579	58,679	40	114,429	55,750	181,179	13
14		Fittings & Fixtures to Dementia Unit		2006	130,960	41,907	5	26,192	(15,715)	41,471	14
15		Concrete Sidewalk		2006	7,050	670	15	470	(200)	744	15
16		Outside Landscaping		2006	19,800	1,881	15	1,320	(561)	2,090	16
17		New Brick Patio		2006	7,400	494	15	494		555	17
18		Dining Area Expansion, Nurses Station & Fitness Club		2007	196,512	2,313	39	4,913	2,600	4,913	18
19		Cabinetry & Lighting for above		2007	45,050	9,010	5	4,505	(4,505)	4,505	19
20		Renovation of Roof		2007	24,000		39	800	800	800	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)	\$ 2,841,518	\$ 122,416		\$ 163,685	\$ 41,269	\$ 347,376	70

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

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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	\$ 347,926	\$ 77,847	\$ 64,320	\$ (13,527)	5	\$ 159,202	71
72	Current Year Purchases	115,450	23,090	12,204	(10,886)	5	12,204	72
73	Fully Depreciated Assets	69,595	426	897	471	5	69,595	73
74			567	567			3,029	74
75	TOTALS	\$ 532,971	\$ 101,930	\$ 77,988	\$ (23,942)		\$ 244,030	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)	\$ 3,374,489	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,346	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 241,673	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,327	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 591,406	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>465,010</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>465,010</u>			7

10. Effective dates of current rental agreement:

Beginning 1 January 2008  
Ending 31 December 2014

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2008</u>	\$ <u>465,010</u>
13.	<u>12/31/2009</u>	\$ <u>465,010</u>
14.	<u>12/31/2010</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: \$ 7,010 Description: Copier @\$1,001.45 for 7 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	<b>TOTAL</b>		\$ _____	\$ _____	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 270,859	\$		\$ 270,859	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			99,958			99,958	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			253,988			253,988	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 prescripts				249,746		249,746	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>**Medical Supplies**</b>	39-2					33,670		33,670	
	<b>**Speciality Beds**</b>	39-2					22,596		22,596	13
14	<b>TOTAL</b>			\$		\$ 624,805	\$ 306,012		\$ 930,817	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 Rehab# 0044859Report Period Beginning: 1-Jan-2007

Ending:

31-Dec-2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 31-Dec-2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 900	\$ 900	1
2	Cash-Patient Deposits	36,903	36,903	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,315,318	2,315,318	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,235	48,235	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,626	1,626	8
9	Other(specify): <b>**Refundable Deposit**</b>	770	770	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,403,752	\$ 2,403,752	10
<b>B. Long-Term Assets</b>				
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	153,567	2,841,518	15
16	Equipment, at Historical Cost	328,060	532,970	16
17	Accumulated Depreciation (book methods)	(346,373)	(611,040)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,506	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,506)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>*Option Deposit*</b>		3,600,000	22
23	Other(specify): <b>**Construction-in-Progress**</b>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 135,254	\$ 6,363,448	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,539,006	\$ 8,767,200	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 234,285	\$ 234,285	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,578	39,578	28
29	Short-Term Notes Payable	890,861	1,588,337	29
30	Accrued Salaries Payable	423,766	423,766	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,129	16,129	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,500	70,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,675,119	\$ 2,372,595	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		4,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 4,000,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,675,119	\$ 6,372,595	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 863,887	\$ 2,394,605	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,539,006	\$ 8,767,200	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>517,458</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>517,458</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>346,429</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>346,429</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>863,887</b>	<b>24</b> *

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

**XVI. STATEMENT OF CHANGES IN EQUITY**

		Total after Consolidation	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,434,436</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,434,436</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>210,169</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>** Shareholder's Loan **</b>	<b>750,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>960,169</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,394,605</b>	<b>24</b> *

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

Facility Name & ID Number Wauconda Healthcare and Rehab

# 0044859

Report Period Beginning: 1-Jan-2007

Ending: 31-Dec-2007

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,636,214	1
2	Discounts and Allowances for all Levels	(2,725,909)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,910,305</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,712,304	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,712,304</b>	8
<b>C. Other Operating Revenue</b>			
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	299,055	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,083	19
20	Radiology and X-Ray	5,205	20
21	Other Medical Services	33,831	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 348,174</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,822	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 3,822</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,974,605</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,684,456	31
32	Health Care	3,394,902	32
33	General Administration	1,172,187	33
<b>B. Capital Expense</b>			
34	Ownership	1,377,376	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	930,817	35
36	Provider Participation Fee	68,438	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,628,176</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>346,429</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 346,429</b>	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. \*\*Offset on Pg 5 & Pg

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

Facility Name & ID Number Wauconda Healthcare and Rehab

# 0044859

Report Period Beginning:

1-Jan-2007

Ending:

31-Dec-2007

**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	1,941	2,190	\$ 78,046	\$ 35.64	1
2	Assistant Director of Nursing	1,398	1,524	40,883	26.83	2
3	Registered Nurses	40,492	43,783	1,146,180	26.18	3
4	Licensed Practical Nurses	6,570	7,299	168,360	23.07	4
5	CNAs & Orderlies	11,560	118,252	1,480,677	12.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	93	198	2,807	14.18	9
10	Activity Assistants	7,096	7,688	94,809	12.33	10
11	Social Service Workers	5,062	5,593	70,896	12.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,108	32,681	325,823	9.97	15
16	Dishwashers					16
17	Maintenance Workers	4,294	4,576	64,713	14.14	17
18	Housekeepers	36,414	38,675	324,328	8.39	18
19	Laundry	4,154	4,545	44,747	9.85	19
20	Administrator	1,980	2,086	59,477	28.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,107	12,103	197,113	16.29	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	1,882	2,156	36,100	16.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,151	283,349	\$ 4,134,959 *	\$ 14.59	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	277	\$ 9,694	1-3	35
36	Medical Director	316	11,400	9-3	36
37	Medical Records Consultant	114	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	54	1,844	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	50	1,623	12-3	45
46	Other(specify) <u>**Dementia**</u>	66	2,173	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	877	\$ 30,958		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,070	\$ 31,995	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,070	\$ 31,995		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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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	Painting & Decorating	May-2007	6,440	3				1,070	2,150	2,150	1,070		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,733		\$ 1,420	\$ 3,094	\$ 4,388	\$ 5,082	\$ 4,488	\$ 3,191	\$ 1,070	\$	\$

