

Facility Name & ID Number Wauconda Healthcare and Rehab

0044859 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-2008

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>45,750</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>45,750</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>2,871</u>	<u>3,014</u>	<u>9,673</u>	<u>15,558</u>	8
9	SNF/PED					9
10	ICF	<u>16,712</u>	<u>7,439</u>	<u>82</u>	<u>24,233</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,583</u>	<u>10,453</u>	<u>9,755</u>	<u>39,791</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.97%

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 9,007

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31st Dec 2008 Fiscal Year: 31st Dec 2008

* 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-2008 Ending: 31-Dec-2008

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	
	A. General Services											
1	Dietary	309,682	26,158	9,883	345,723		345,723		345,723			1
2	Food Purchase		254,417		254,417	(15,082)	239,335	(655)	238,680			2
3	Housekeeping	337,535	69,667		407,202		407,202		407,202			3
4	Laundry	34,645	28,550		63,195		63,195		63,195			4
5	Heat and Other Utilities			249,064	249,064		249,064		249,064			5
6	Maintenance	63,378	56,199	197,831	317,408		317,408	6,791	324,199			6
7	Other (specify):*											7
8	TOTAL General Services	745,240	434,991	456,778	1,637,009	(15,082)	1,621,927	6,136	1,628,063			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,096,539	182,731	76,976	3,356,246		3,356,246		3,356,246			10
10a	Therapy		3,903	893	4,796		4,796		4,796			10a
11	Activities	100,753	37,399	2,076	140,228		140,228		140,228			11
12	Social Services	72,215		1,190	73,405		73,405		73,405			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,269,507	224,033	95,535	3,589,075		3,589,075		3,589,075			16
	C. General Administration											
17	Administrative	66,242		157,500	223,742		223,742	(68,307)	155,435			17
18	Directors Fees											18
19	Professional Services			36,754	36,754		36,754	5,166	41,920			19
20	Dues, Fees, Subscriptions & Promotions			46,741	46,741		46,741	(28,782)	17,959			20
21	Clerical & General Office Expenses	166,790	47,227	251,994	466,011		466,011	(165,100)	300,911			21
22	Employee Benefits & Payroll Taxes			669,030	669,030	15,082	684,112	10,996	695,108			22
23	Inservice Training & Education			1,987	1,987		1,987	150	2,137			23
24	Travel and Seminar			2,228	2,228		2,228	300	2,528			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			757,953	757,953		757,953		757,953			26
27	Other (specify):* *Payroll taxes Sch VII**							13,608	13,608			27
28	TOTAL General Administration	233,032	47,227	1,924,187	2,204,446	15,082	2,219,528	(231,969)	1,987,559			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,247,779	706,251	2,476,500	7,430,530		7,430,530	(225,833)	7,204,697			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-2008 Ending: 31-Dec-2008

31-Dec-2008

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	
	D. Ownership											
30	Depreciation			57,607	57,607	57,607	207,705	265,312				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,411	14,411	14,411	555,532	569,943				32
33	Real Estate Taxes			200,930	200,930	200,930		200,930				33
34	Rent-Facility & Grounds			1,200,773	1,200,773	1,200,773	(734,990)	465,783				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,473,721	1,473,721	1,473,721	28,247	1,501,968				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		344,248	828,096	1,172,344	1,172,344		1,172,344				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,625	68,625	68,625		68,625				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		344,248	896,721	1,240,969	1,240,969		1,240,969				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,247,779	1,050,499	4,846,942	10,145,220	10,145,220	(197,586)	9,947,634				45

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

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	44,499	30		9
10	Interest and Other Investment Income	(57)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(655)	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		24		19
20	Contributions	(15)	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	(226,513)	21		24
25	Fund Raising, Advertising and Promotional	(59,508)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,089)	20		28
29	Other-Attach Schedule	3,571	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (239,767)		\$	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)	42,181	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 42,181		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (197,586)		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					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 Rehab

ID# 0044859

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance Costs (expended in 2008)	\$ (1,375)	6	1
2	Deferred Maintenance Costs (to write off in 2008)	4,946	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	3,571		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehab

0044859

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008

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	(655)	0	0	0	0	0	0	0	0	0	0	(655)	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	3,571	3,220	0	0	0	0	0	0	0	0	0	6,791	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	2,916	3,220	0	0	0	0	0	0	0	0	0	6,136	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	(68,307)	0	0	0	0	0	0	0	0	0	(68,307)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,041	1,125	0	0	0	0	0	0	0	0	5,166	19
20	Fees, Subscriptions & Promotions	(60,612)	31,830	0	0	0	0	0	0	0	0	0	(28,782)	20
21	Clerical & General Office Expenses	(226,513)	61,413	0	0	0	0	0	0	0	0	0	(165,100)	21
22	Employee Benefits & Payroll Taxes	0	10,996	0	0	0	0	0	0	0	0	0	10,996	22
23	Inservice Training & Education	0	150	0	0	0	0	0	0	0	0	0	150	23
24	Travel and Seminar	0	300	0	0	0	0	0	0	0	0	0	300	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	13,608	0	0	0	0	0	0	0	0	0	13,608	27
28	TOTAL General Administration	(287,125)	54,031	1,125	0	(231,969)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(284,209)	57,251	1,125	0	(225,833)	29							

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehab

0044859

Report Period Beginning:

1-Jan-2008 Ending:

Summary B

31-Dec-2008

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	44,499	5,883	157,323	0	0	0	0	0	0	0	0	207,705	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57)	(30,790)	586,379	0	0	0	0	0	0	0	0	555,532	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	TOTAL Ownership	44,442	(24,907)	8,712	0	28,247	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)	(239,767)	32,344	9,837	0	(197,586)	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	\$ 157,500	Lancaster, Ltd.	100.00%	\$	\$ (157,500)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	35,872	35,872	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	4,041	4,041	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	61,413	61,413	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	10,996	10,996	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	300	300	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	53,321	53,321	7
8	V	20 Marketing, Fees & Subscriptions		Lancaster, Ltd.	100.00%	31,830	31,830	8
9	V	30 Depreciation		Lancaster, Ltd.	100.00%	5,883	5,883	9
10	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	13,608	13,608	10
11	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	150	150	11
12	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	3,220	3,220	12
13	V	32 *Direct Interest*	30,790	Lancaster, Ltd.	100.00%		(30,790)	13
14	Total		\$ 188,290			\$ 220,634	\$ * 32,344	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)
16	V	32 Interest		Wauconda Associates		586,379	586,379
17	V	30 Depreciation		Wauconda Associates		157,323	157,323
18	V	19 Accounting Fees		Wauconda Associates		1,125	1,125
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,200,000			\$ 1,209,837	\$ * 9,837

* 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-2008 Ending: 31-Dec-2008

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	\$ 17,936	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	17,936	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	\$ 35,872		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-2008

Ending: -Dec-2008

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	\$ 172,189	\$ 172,189	5	\$ 17,936	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		5	970	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	5	17,936	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		5	970	4
5										5
6										6
7										7
8										8
9										9
10	19	Professional Services	Management Fees	1,694,700	7	43,482		157,500	4,041	10
11	21	Clerical Expenses	Management Fees	1,694,700	7	660,800	590,769	157,500	61,413	11
12	22	Employee Benefits	Management Fees	1,694,700	7	118,314		157,500	10,996	12
13	24	Seminars and Travel	Management Fees	1,694,700	7	3,223		157,500	300	13
14	17	Administrative Consulting	Management Fees	1,694,700	7	573,729	573,729	157,500	53,321	14
15	20	Marketing Fees	Management Fees	1,694,700	7	336,332	316,659	157,500	31,258	15
16	30	Depreciation	Management Fees	1,694,700	7	63,305		157,500	5,883	16
17	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	6,153		157,500	572	17
18	27	Payroll Taxes	Management Fees	1,694,700	7	125,546		157,500	11,668	18
19	23	Education and Inservice	Management Fees	1,694,700	7	1,615		157,500	150	19
20	6	Repairs and Maintenance	Management Fees	1,694,700	7	34,646		157,500	3,220	20
21	32	*Direct Interest*								21
22										22
23										23
24										24
25	TOTALS					\$ 2,330,141	\$ 1,825,534		\$ 220,634	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	Harston Investments		X	Working Capital						570,000	6									
7											7									
8											8									
9	TOTAL Facility Related									570,000	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									570,000	15									

Less: Interest Income (57)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A 569,943

* 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	70,500	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.)		\$	135,430	2
3. Under or (over) accrual (line 2 minus line 1).		\$	64,930	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	136,000	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.		\$	200,930	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	58,529	8	
	2004	56,130	9	
	2005	58,647	10	
	2006	68,274	11	
	2007	135,430	12	
Accrual is based on weighted average of last 4 year's taxes; adjusted for inflation				
** More weightage is placed on 2007 taxes due to new construction**				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 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 2007 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 2007.

(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>129,111.48</u>	\$ <u>129,111.48</u>
2. <u>09-35-200-059</u>	<u>Long-Term HealthCare</u>	\$ <u>6,128.28</u>	\$ <u>6,128.28</u>
3. <u>09-35-200-057</u>	<u>Long-Term HealthCare</u>	\$ <u>190.18</u>	\$ <u>190.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>135,429.94</u>	\$ <u>135,429.94</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: None 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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		1,722	9
10		Nurses' Call System		2001	18,785	1,005	7	1,435	430	18,785	10
11		Fire Protection System		2001	99,420	5,317	7	7,595	2,278	99,420	11
12		Nurse Call Additions		2002	1,100	69	7	73	4	464	12
13		Construction of Dementia Unit		2006	2,288,579	58,679	40	114,429	55,750	295,608	13
14		Fittings & Fixtures to Dementia Unit		2006	130,960	25,144	5	26,192	1,048	67,663	14
15		Concrete Sidewalk		2006	7,050	603	15	470	(133)	1,214	15
16		Outside Landscaping		2006	19,800	1,693	15	1,320	(373)	3,410	16
17		New Brick Patio		2006	7,400	494	15	494		1,049	17
18		Dining Area Expansion, Nurses Station & Fitness Club		2007	196,512	5,039	39	9,826	4,787	14,739	18
19		Cabinetry & Lighting for above		2007	45,050	14,416	5	9,010	(5,406)	13,515	19
20		Renovation of Roof		2007	24,000		39	2,400	2,400	3,200	20
21		Conversion of Rehabilitation Room		2008	38,795	42		162	120	162	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wauconda Healthcare and Rehab

0044859

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008

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)	\$ 2,880,313	\$ 112,670		\$ 173,575	\$ 60,905	\$ 520,951	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 418,448	\$ 83,335	\$ 79,171	\$ (4,164)	5	\$ 209,499	71
72	Current Year Purchases	31,163	17,651	2,834	(14,817)	5	2,834	72
73	Fully Depreciated Assets	114,523	1,275	3,850	2,575	5	114,523	73
74			5,883	5,883			8,912	74
75	TOTALS	\$ 564,134	\$ 108,144	\$ 91,738	\$ (16,406)		\$ 335,768	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)	\$ 3,444,447	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,814	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 265,313	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,499	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 856,719	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	<u>Storage Pods</u>				<u>773</u>			5
6								6
7	TOTAL				\$ <u>465,783</u>			7

10. Effective dates of current rental agreement:

Beginning 1 January 2008

Ending 31 January 2009

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

Fiscal Year Ending Annual Rent

12. 12/31/2009 \$ 38,751 (1 Month)

13. _____ \$ _____

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: Exercised Option to Buy & Closed on 1st Feb 2009 *

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: \$ _____ Description: _____

(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	\$		\$ 348,051	\$		\$ 348,051	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			109,265			109,265	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			370,780			370,780	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				306,945		306,945	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					21,092		21,092	12
13	Other (specify): **Speciality Beds**	39-2					16,211		16,211	13
14	TOTAL			\$		\$ 828,096	\$ 344,248		\$ 1,172,344	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-2008

Ending:

31-Dec-2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 31-Dec-2008 (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	41,834	41,834	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,494,118	2,494,118	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,167	42,167	6
7	Other Prepaid Expenses	3,276	3,276	7
8	Accounts Receivable (owners or related parties)	3,855	3,855	8
9	Other(specify): **Refundable Deposit**	1,550	1,550	9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 2,587,700	\$ 2,587,700	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	2,856,313	15
16	Equipment, at Historical Cost	347,643	564,133	16
17	Accumulated Depreciation (book methods)	(403,980)	(825,970)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(14,507)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Option Deposit**)		3,625,000	22
23	Other(specify): **Construction-in-Progress**		10,422	23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 73,230	\$ 6,229,898	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 2,660,930	\$ 8,817,598	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 658,787	\$ 658,787	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,834	41,834	28
29	Short-Term Notes Payable	1,069,984	1,705,771	29
30	Accrued Salaries Payable	477,379	477,379	30
	Accrued Taxes Payable (excluding real estate taxes)	17,869	17,869	31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,000	136,000	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
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 2,401,853	\$ 3,037,640	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
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$	\$ 4,000,000	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 2,401,853	\$ 7,037,640	46
47	TOTAL EQUITY (page 18, line 24)	\$ 259,077	\$ 1,779,958	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ 2,660,930	\$ 8,817,598	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 863,887	1
2	Restatements (describe):		2
3			3
4	Adjustments for Tax Purposes	(24,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 839,887	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(580,810)	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)	\$ (580,810)	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)	\$ 259,077	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after cosolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,644,605	1
2	Restatements (describe):		2
3			3
4	Adjustments for Tax Purposes	(24,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,620,605	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(590,647)	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)	\$ 159,353	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,779,958	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Healthcare and Rehab

0044859

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

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	\$ 10,595,937	1
2	Discounts and Allowances for all Levels	(3,389,907)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,206,030	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,028,077	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,028,077	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	301,152	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,654	19
20	Radiology and X-Ray	6,842	20
21	Other Medical Services	10,598	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 330,246	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	57	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57	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)	\$ 9,564,410	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,637,009	31
32	Health Care	3,589,075	32
33	General Administration	2,204,446	33
B. Capital Expense			
34	Ownership	1,473,721	34
C. Ancillary Expense			
35	Special Cost Centers	1,172,344	35
36	Provider Participation Fee	68,625	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,145,220	40
41	Income before Income Taxes (line 30 minus line 40)**	(580,810)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (580,810)	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-2008

Ending:

31-Dec-2008

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	1,905	2,076	\$ 70,630	\$ 34.02	1
2	Assistant Director of Nursing	625	806	25,485	31.62	2
3	Registered Nurses	41,727	44,544	1,276,848	28.66	3
4	Licensed Practical Nurses	5,883	6,444	153,287	23.79	4
5	CNAs & Orderlies	114,293	122,851	1,534,286	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	706	731	11,618	15.89	9
10	Activity Assistants	6,596	7,256	89,135	12.28	10
11	Social Service Workers	5,065	5,494	72,215	13.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,643	29,913	309,682	10.35	15
16	Dishwashers					16
17	Maintenance Workers	3,823	4,331	63,378	14.63	17
18	Housekeepers	35,276	38,008	337,535	8.88	18
19	Laundry	3,203	3,371	34,645	10.28	19
20	Administrator	1,921	2,091	66,242	31.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,706	11,620	166,790	14.35	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	1,866	2,091	36,003	17.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	261,238	281,627	\$ 4,247,779 *	\$ 15.08	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	300	\$ 9,883	1-3	35
36	Medical Director	400	14,400	9-3	36
37	Medical Records Consultant	131	4,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	27	893	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	67	2,076	11-3	44
45	Social Service Consultant	38	1,190	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	963	\$ 32,762		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,595	\$ 72,656	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,595	\$ 72,656		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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Painting & Decorating	Mar-2004	\$ 1,000	3	\$ 333	\$ 333	\$ 167	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	Apr-2004	2,000	3	667	667	333						
3	Painting & Decorating	Apr-2004	5,515	3	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	Painting & Decorating	Apr-2008	1,375	3				458	459	458			
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 24,108		\$ 3,094	\$ 4,388	\$ 5,082	\$ 4,946	\$ 3,650	\$ 1,528	\$	\$	\$

