

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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 29-Dec-2009

	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>135</u>	<u>45,655</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>135</u>	<u>45,655</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>517</u>	<u>2,945</u>	<u>9,802</u>	<u>13,264</u>	8	
9	SNF/PED					9	
10	ICF	<u>16,799</u>	<u>10,382</u>	<u>228</u>	<u>27,409</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>17,316</u>	<u>13,327</u>	<u>10,030</u>	<u>40,673</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.09%

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 135 and days of care provided 9,207

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAAL MODIFIED CASH* CASH*

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

Tax Year: 31st Dec 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	315,716	27,997	8,759	352,472		352,472		352,472		1
2	Food Purchase		217,696		217,696	(15,613)	202,083	(685)	201,398		2
3	Housekeeping	307,015	81,052		388,067		388,067		388,067		3
4	Laundry	60,137	35,328		95,465		95,465		95,465		4
5	Heat and Other Utilities			225,917	225,917		225,917		225,917		5
6	Maintenance	63,901	79,378	159,025	302,304		302,304	4,406	306,710		6
7	Other (specify):*										7
8	TOTAL General Services	746,769	441,451	393,701	1,581,921	(15,613)	1,566,308	3,721	1,570,029		8
	B. Health Care and Programs										
9	Medical Director			15,900	15,900		15,900		15,900		9
10	Nursing and Medical Records	3,480,846	265,690	155,528	3,902,064		3,902,064		3,902,064		10
10a	Therapy		9,588	9,429	19,017		19,017		19,017		10a
11	Activities	83,698	34,893	1,774	120,365		120,365		120,365		11
12	Social Services	58,126		713	58,839		58,839		58,839		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,622,670	310,171	183,344	4,116,185		4,116,185		4,116,185		16
	C. General Administration										
17	Administrative	78,095		210,000	288,095		288,095	(110,611)	177,484		17
18	Directors Fees										18
19	Professional Services			24,763	24,763		24,763	30,075	54,838		19
20	Dues, Fees, Subscriptions & Promotions			50,049	50,049		50,049	(19,252)	30,797		20
21	Clerical & General Office Expenses	191,309	52,878	121,547	365,734		365,734	(26,157)	339,577		21
22	Employee Benefits & Payroll Taxes			768,451	768,451	15,613	784,064	7,156	791,220		22
23	Inservice Training & Education			7,945	7,945		7,945	2,346	10,291		23
24	Travel and Seminar			5,456	5,456		5,456	1,013	6,469		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,537	7,537		7,537		7,537		26
27	Other (specify):* *Payroll Taxes (Sch VII)							15,875	15,875		27
28	TOTAL General Administration	269,404	52,878	1,195,748	1,518,030	15,613	1,533,643	(99,555)	1,434,088		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,638,843	804,500	1,772,793	7,216,136		7,216,136	(95,834)	7,120,302		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

#0044859

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			69,270	69,270		69,270	339,322	408,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,588	12,588		12,588	855,398	867,986			32
33	Real Estate Taxes			149,567	149,567		149,567		149,567			33
34	Rent-Facility & Grounds			1,206,722	1,206,722		1,206,722	(1,161,249)	45,473			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,438,147	1,438,147		1,438,147	33,471	1,471,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		405,412	803,704	1,209,116		1,209,116		1,209,116			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,483	68,483		68,483		68,483			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		405,412	872,187	1,277,599		1,277,599		1,277,599			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,638,843	1,209,912	4,083,127	9,931,882		9,931,882	(62,363)	9,869,519			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	(32,829)	30		9
10	Interest and Other Investment Income	(15,876)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(685)	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	(1,595)	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	(96,059)	21		24
25	Fund Raising, Advertising and Promotional	(59,437)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,128)	20		28
29	Other-Attach Schedule	2,594	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (205,015)		\$	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)	142,652	Pg 6& 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 142,652		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (62,363)		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 Rehabilitation

ID# 0044859

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deferred Maintenance Costs (expended in 2009)	\$ (1,267)	6	1
2	Deferred Maintenance Costs (to write off in 2009)	3,861	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	2,594		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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	(685)	0	0	0	0	0	0	0	0	0	0	(685)	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	2,594	1,812	0	0	0	0	0	0	0	0	0	4,406	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,909	1,812	0	0	0	0	0	0	0	0	0	3,721	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	(110,611)	0	0	0	0	0	0	0	0	0	(110,611)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,002	27,073	0	0	0	0	0	0	0	0	30,075	19
20	Fees, Subscriptions & Promotions	(62,160)	42,908	0	0	0	0	0	0	0	0	0	(19,252)	20
21	Clerical & General Office Expenses	(96,059)	69,902	0	0	0	0	0	0	0	0	0	(26,157)	21
22	Employee Benefits & Payroll Taxes	0	7,156	0	0	0	0	0	0	0	0	0	7,156	22
23	Inservice Training & Education	0	2,346	0	0	0	0	0	0	0	0	0	2,346	23
24	Travel and Seminar	0	1,013	0	0	0	0	0	0	0	0	0	1,013	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	15,875	0	0	0	0	0	0	0	0	0	15,875	27
28	TOTAL General Administration	(158,219)	31,591	27,073	0	(99,555)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(156,310)	33,403	27,073	0	(95,834)	29							

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(32,829)	2,415	369,736	0	0	0	0	0	0	0	0	339,322	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,876)	(9,845)	881,119	0	0	0	0	0	0	0	0	855,398	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,161,249)	0	0	0	0	0	0	0	0	(1,161,249)	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	(48,705)	(7,430)	89,606	0	33,471	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(205,015)	25,973	116,679	0	0	0	0	0	0	0	0	(62,363)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fee Income	\$ 210,000	Lancaster, Ltd.	100.00%	\$	(210,000)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	35,872	35,872	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	15,875	15,875	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	3,002	3,002	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	69,902	69,902	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	7,156	7,156	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	1,013	1,013	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	63,517	63,517	8
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	42,908	42,908	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	2,415	2,415	10
11	V	32 Interest-Incl. Direct Interest	15,373	Lancaster, Ltd.	100.00%	5,528	(9,845)	11
12	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	2,346	2,346	12
13	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	1,812	1,812	13
14	Total		\$ 225,373			\$ 251,346	\$ * 25,973	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		\$ 38,751	\$ (1,161,249)
16	V	32 Interest		Wauconda Associates		2,785	2,785
17	V	32 Interest		Wauconda Associates		610,562	610,562
18	V	32 Mortgage Interest		Wauconda Associates		267,772	267,772
19	V	30 Depreciation		Wauconda Associates		369,736	369,736
20	V	19 Accounting Fees		Wauconda Associates		1,225	1,225
21	V	19 Legal Fees				25,848	25,848
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			\$ 1,316,679	\$ * 116,679

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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 Rehabilitation

0044859

Report Period Beginning:

1-Jan-2009

Ending: -Dec-2009

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

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

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

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	19	Professional Services	Management Fees	2,190,720	7	31,315		210,000	3,002	8
9	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	210,000	69,902	9
10	22	Employee Benefits	Management Fees	2,190,720	7	74,654		210,000	7,156	10
11	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		210,000	1,013	11
12	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	210,000	63,517	12
13	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	210,000	41,276	13
14	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		210,000	1,632	14
15	30	Depreciation	Management Fees	2,190,720	7	25,194		210,000	2,415	15
16	32	Interest	Management Fees	2,190,720	7	57,668		210,000	5,528	16
17	23	Education & Inservice	Management Fees	2,190,720	7	24,476		210,000	2,346	17
18	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		210,000	1,812	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		210,000	13,935	19
20										20
21	32	*Direct Interest*								21
22										22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 251,346	25

Facility Name & ID Number

Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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										
										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	LaSalle National Trust, N.A.		X	Mortgage	\$32,345.15	Feb 2009	\$ 3,595,000	\$ 3,539,320	Jan 2029	9.0000	\$ 267,772	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Harston Investments		X	Working Capital							610,562	6							
7	JP Morgan Chase Bank		X	Working Capital							5,528	7							
8												8							
9	TOTAL Facility Related				\$32,345.15		\$ 3,595,000	\$ 3,539,320			\$ 883,862	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,595,000	\$ 3,539,320			\$ 883,862	15							

Less: Interest Income (15,876)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ None

Line #

N/A

867,986

* 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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,038 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>155,632</u>	<u>2009</u>	<u>\$ 389,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	155,632		\$ 389,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	125	2009		\$ 7,131,000	\$ 249,643	39	\$ 145,822	\$ (103,821)	\$ 145,822	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Redwood Sign 4x6		2000	2,862	169	15	169		1,891	9
10	Nurses' Call System		2001	18,785		7			18,785	10
11	Fire Protection System		2001	99,420		7			99,420	11
12	Nurse Call Additions		2002	1,100	34	7	73	39	537	12
13	Construction of Dementia Unit		2006	2,288,579	58,678	40	114,429	55,751	410,037	13
14	Fittings & Fixtures to Dementia Unit		2006	130,960	15,087	5	26,192	11,105	93,855	14
15	Concrete Sidewalk		2006	7,050	543	15	470	(73)	1,684	15
16	Outside Landscaping		2006	19,800	1,525	15	1,320	(205)	4,730	16
17	New Brick Patio		2006	7,400	494	15	494		1,543	17
18	Dining Area Expansion, Nurses Station & Fitness Club		2007	196,512	5,039	39	9,826	4,787	24,565	18
19	Cabinetry & Lighting for above		2007	45,050	8,650	5	9,010	360	22,525	19
20	Renovation of Roof		2007	24,000		39	2,400	2,400	5,600	20
21	Preconstruction planning, Architectural & Auto CAD Work		2008	4,295	110	15	214	104	232	21
22	Demolition, Removal of Debris & Temporary Costructor		2008	3,500	89	15	175	86	192	22
23	Reconstruction of Dry Wall, Windows & Doors per Plan		2008	26,000	666	15	1,300	634	1,407	23
24	Installation of Suspended Ceiling & Electrical fitting/pipes		2008	5,000	128	15	250	122	270	24
25	Resurfacing of Parking Lot		2009	8,165	4,287	15	363	(3,924)	363	25
26	Fire Rated Door Frame & Fixtures		2009	1,870	18	10	78	60	78	26
27	Hot water heating Boiler		2009	11,500	86	10	383	297	383	27
28	Mirrored Walls, Windows & Tiles in Therapy Room		2009	16,748	305	10	1,256	951	1,256	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)		\$ 10,049,596	\$ 345,551		\$ 314,224	\$ (31,327)	\$ 835,175	70

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation

0044859

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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	\$ 423,427	\$ 56,131	\$ 79,383	\$ 23,252		\$ 268,280	71
72	Current Year Purchases	61,080	36,649	9,822	(26,827)		9,822	72
73	Fully Depreciated Assets	140,707	675	2,748	2,073		140,707	73
74	**Lancaster Allocation**		2,415	2,415			11,327	74
75	TOTALS	\$ 625,214	\$ 95,870	\$ 94,368	\$ (1,502)		\$ 430,136	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)	\$ 11,063,810	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 441,421	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 408,592	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,829)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,265,311	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*** (For January 2009-1 Month)

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:			\$ 38,751			3
4	Additions						4
5	**Storage Pods**			120			5
6	**Off-site Clerical Office**			6,602			6
7	TOTAL			\$ 45,473			7

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

10. Effective dates of current rental agreement:

Beginning 1 January 2009

Ending 31 January 2009

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

Fiscal Year Ending Annual Rent

12. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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	\$		\$ 324,516	\$		\$ 324,516	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			113,231			113,231	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			365,957			365,957	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				353,131		353,131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					32,995		32,995	12
13	Other (specify): **Speciality Beds**	39-2					19,286		19,286	13
14	TOTAL			\$		\$ 803,704	\$ 405,412		\$ 1,209,116	14

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

Facility Name & ID Number **Wauconda Healthcare and Rehabilitation**# **0044859**Report Period Beginning: **1-Jan-2009**

Ending:

31-Dec-2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **31-Dec-2009** (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	41,317	41,317	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,647,799	2,647,799	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,950	34,950	6
7	Other Prepaid Expenses	2,500	2,500	7
8	Accounts Receivable (owners or related parties)	3,240	3,240	8
9	Other(specify): **Refundable Deposit**	1,550	1,550	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,732,256	\$ 2,732,256	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		389,000	13
14	Buildings, at Historical Cost		6,131,000	14
15	Leasehold Improvements, at Historical Cost	167,851	3,894,597	15
16	Equipment, at Historical Cost	408,723	625,213	16
17	Accumulated Depreciation (book methods)	(473,250)	(1,264,976)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,507)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction-in-Progress**	11,954	22,376	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 115,278	\$ 9,797,210	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,847,534	\$ 12,529,466	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 266,948	\$ 266,948	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,541	41,541	28
29	Short-Term Notes Payable	1,311,853	5,089,583	29
30	Accrued Salaries Payable	510,900	510,900	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,873	19,873	31
32	Accrued Real Estate Taxes(Sch.IX-B)	143,000	143,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,294,115	\$ 6,071,845	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		4,500,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,500,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,294,115	\$ 10,571,845	46
47	TOTAL EQUITY(page 18, line 24)	\$ 553,419	\$ 1,957,621	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,847,534	\$ 12,529,466	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 259,077	1
2	Restatements (describe):		2
3			3
4	Adjustments for Tax Purposes		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 259,077	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	294,342	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)	\$ 294,342	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)	\$ 553,419	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,029,958	1
2	Restatements (describe):		2
3			3
4	Adjustments for Tax Purposes		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,029,958	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	177,663	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)	\$ 927,663	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)	\$ 1,957,621	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**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	\$ 11,259,513	1
2	Discounts and Allowances for all Levels	(3,506,303)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,753,210	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,985,087	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,985,087	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	384,767	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,424	19
20	Radiology and X-Ray	13,720	20
21	Other Medical Services	61,140	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 472,051	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,876	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,876	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)	\$ 10,226,224	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,581,921	31
32	Health Care	4,116,185	32
33	General Administration	1,518,030	33
B. Capital Expense			
34	Ownership	1,438,147	34
C. Ancillary Expense			
35	Special Cost Centers	1,209,116	35
36	Provider Participation Fee	68,483	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,931,882	40
41	Income before Income Taxes (line 30 minus line 40)**	294,342	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 294,342	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 6

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

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

0044859

Report Period Beginning: **1-Jan-2009**

Ending:

31-Dec-2009

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	1,790	2,086	\$ 73,798	\$ 35.38	1
2	Assistant Director of Nursing	1,828	2,141	68,364	31.93	2
3	Registered Nurses	42,020	45,985	1,338,003	29.10	3
4	Licensed Practical Nurses	6,946	7,657	180,035	23.51	4
5	CNAs & Orderlies	131,815	142,332	1,782,712	12.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,019	2,094	33,578	16.04	9
10	Activity Assistants	3,381	3,912	50,120	12.81	10
11	Social Service Workers	3,824	4,289	58,126	13.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,743	29,138	315,716	10.84	15
16	Dishwashers					16
17	Maintenance Workers	3,732	4,190	63,901	15.25	17
18	Housekeepers	31,139	33,592	307,015	9.14	18
19	Laundry	5,393	6,511	60,137	9.24	19
20	Administrator	1,918	2,104	78,095	37.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,167	12,938	191,309	14.79	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	1,813	2,086	37,934	18.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,528	301,055	\$ 4,638,843 *	\$ 15.41	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	303	\$ 8,759	1-3	35
36	Medical Director	423	15,900	9-3	36
37	Medical Records Consultant	140	4,352	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	165	5,037	10a-3	40
41	Occupational Therapy Consultant	98	2,914	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	1,478	10a-3	43
44	Activity Consultant	62	1,774	11-3	44
45	Social Service Consultant	26	713	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,270	\$ 40,927		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,047	\$ 151,176	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,047	\$ 151,176		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kathryn Berg	Administrator	N/A	\$ 78,095	Workers' Compensation Insurance	\$ 65,150	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	28,532	Advertising: Employee Recruitment	1,038	
				FICA Taxes	346,113	Health Care Worker Background Check	4,536	
				Employee Health Insurance	268,120	(Indicate # of checks performed <u>378</u>)		
				Employee Meals	15,613	Patient Background Checks <u>172</u>	2,064	
				Illinois Municipal Retirement Fund (IMRF)*		***Advertising & Promotions***	20,117	
				Misc. Employee Benefits	9,986	***Licenses and Fees***	18,437	
				Employee Uniforms		***Dues and Subscriptions***	2,862	
				Retirement Plan Contributions	50,550			
				Employment Fees		***Lancaster Allocation***	42,908	
						Less: Public Relations Expense	(18,124)	
						Non-allowable advertising	(42,908)	
						Yellow page advertising	(1,128)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,095	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 791,220		\$ 30,797		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Lancaster, Ltd.			\$ 210,000				Out-of-State Travel	\$
							In-State Travel	1,087
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 210,000				Seminar Expense	4,369
C. Professional Services							***Lancaster Allocation***	1,013
Vendor/Payee	Type		Amount				Entertainment Expense	()
Personnel Planners	Unemployment Tax Consult		\$ 1,180				(agree to Sch. V, line 24, col. 8)	
Richard Peelo	Accounting		2,250	** N/A **			TOTAL	\$ 6,469
Frost Ruttenberg & Rothblatt	Accounting		1,700					
Law Office of Carter Korey	Legal		10,930					
Accu-Med Services Inc.	Data Processing		700					
Health Data Systems	Data Processing		5,922					
SigmaCare Services	Data Processing		1,800					
LTCAC, Inc.	Data Processing		281					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,763	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting & Decorating	Mar-2004	\$ 1,000	3	\$ 333	\$ 167																		
2	Painting & Decorating	Apr-2004	2,000	3	667	333																		
3	Painting & Decorating	Apr-2004	5,515	3	1,837	920																		
4	Painting & Decorating	Sep-2005	1,532	3	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	Painting & Decorating	Jul-2009	1,267	3				211	422	422	212													
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 25,375		\$ 4,388	\$ 5,082	\$ 4,946	\$ 3,861	\$ 1,950	\$ 422	\$ 212	\$	\$											

Facility Name & ID Number Wauconda Healthcare and Rehabilitation# 0044859Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,657 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 68,483
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,613 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.