

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859 Report Period Beginning: 1-Jan-2013 Ending: 31-Dec-2013

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	135	Skilled (SNF)	135	49,275	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	135	TOTALS	135	49,275	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	120	665	11,334	12,119	8
9	SNF/PED					9
10	ICF	16,603	10,511	328	27,442	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,723	11,176	11,662	39,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.29%

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 9,952

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 31st Dec 2013 Fiscal Year: 31st Dec 2013

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

Facility Name & ID Number

Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

1-Jan-2013

Ending:

31-Dec-2013

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	401,068	35,000	17,293	453,361		453,361	453,361			1
2	Food Purchase		302,324		302,324	(23,842)	278,482	(797)	277,685		2
3	Housekeeping	323,791	66,145		389,936		389,936	389,936			3
4	Laundry	66,986	33,643		100,629		100,629	100,629			4
5	Heat and Other Utilities			197,249	197,249		197,249	197,249			5
6	Maintenance	49,797	219,850	168,122	437,769		437,769	4,810	442,579		6
7	Other (specify):*										7
8	TOTAL General Services	841,642	656,962	382,664	1,881,268	(23,842)	1,857,426	4,013	1,861,439		8
	B. Health Care and Programs										
9	Medical Director			21,900	21,900		21,900	21,900			9
10	Nursing and Medical Records	3,565,602	283,230	111,988	3,960,820		3,960,820	3,960,820			10
10a	Therapy		12,526	56,809	69,335		69,335	69,335			10a
11	Activities	80,289	45,320		125,609		125,609	125,609			11
12	Social Services	75,672		5,760	81,432		81,432	81,432			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,721,563	341,076	196,457	4,259,096		4,259,096	4,259,096			16
	C. General Administration										
17	Administrative	70,854		453,600	524,454		524,454	(175,050)	349,404		17
18	Directors Fees										18
19	Professional Services			58,851	58,851		58,851	12,497	71,348		19
20	Dues, Fees, Subscriptions & Promotions			66,316	66,316		66,316	(43,580)	22,736		20
21	Clerical & General Office Expenses	209,265	43,300	160,872	413,437		413,437	2,902	416,339		21
22	Employee Benefits & Payroll Taxes			822,597	822,597	23,842	846,439	20,326	866,765		22
23	Inservice Training & Education			5,006	5,006		5,006	5,547	10,553		23
24	Travel and Seminar			5,997	5,997		5,997	573	6,570		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,619	35,619		35,619		35,619		26
27	Other (specify):* *Payroll Taxes (Sch VII)							32,732	32,732		27
28	TOTAL General Administration	280,119	43,300	1,608,858	1,932,277	23,842	1,956,119	(144,053)	1,812,066		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,843,324	1,041,338	2,187,979	8,072,641		8,072,641	(140,040)	7,932,601		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 & Rehab

#0044859

Report Period Beginning:

1-Jan-2013

Ending:

31-Dec-2013

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			50,918	50,918	50,918	544,672	595,590				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						857,109	857,109				32
33	Real Estate Taxes			244,973	244,973	244,973	3,884	248,857				33
34	Rent-Facility & Grounds			1,254,558	1,254,558	1,254,558	(1,200,000)	54,558				34
35	Rent-Equipment & Vehicles			21,540	21,540	21,540		21,540				35
36	Other (specify):*											36
37	TOTAL Ownership			1,571,989	1,571,989	1,571,989	205,665	1,777,654				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		528,740	1,136,715	1,665,455	1,665,455		1,665,455				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,912	73,912	73,912		73,912				42
43	Other (specify):* *Assessment Tax @\$6.07**			179,727	179,727	179,727		179,727				43
44	TOTAL Special Cost Centers		528,740	1,390,354	1,919,094	1,919,094		1,919,094				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,843,324	1,570,078	5,150,322	11,563,724	11,563,724	65,625	11,629,349				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	144,168	30		9
10	Interest and Other Investment Income	(34,010)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(797)	2		13
14	Non-Care Related Interest	(4,632)	32		14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(600)	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	(118,395)	21		24
25	Fund Raising, Advertising and Promotional	(112,166)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule Attached Schedule 5A	4,418	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (122,014)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	187,639	6,6A&6B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 187,639		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 65,625		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

Wauconda Healthcare & Rehab

ID# 0044859

Report Period Beginning: 1-Jan-2013

Ending: 31-Dec-2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance Cost (incurred in 2013)	\$ (2,422)	6	1
2	Deferred Maintenance Cost (allocated for 2013)	6,840	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		4,418	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare & Rehab# 0044859

Report Period Beginning:

1-Jan-2013

Ending:

31-Dec-2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(797)	0	0	0	0	0	0	0	0	0	0	(797)	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	4,418	392	0	0	0	0	0	0	0	0	0	4,810	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	3,621	392	0	0	0	0	0	0	0	0	0	4,013	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	157,714	(332,764)	0	0	0	0	0	0	0	0	(175,050)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,468	0	8,029	0	0	0	0	0	0	0	12,497	19
20	Fees, Subscriptions & Promotions	(112,766)	69,186	0	0	0	0	0	0	0	0	0	(43,580)	20
21	Clerical & General Office Expenses	(118,395)	121,297	0	0	0	0	0	0	0	0	0	2,902	21
22	Employee Benefits & Payroll Taxes	0	20,326	0	0	0	0	0	0	0	0	0	20,326	22
23	Inservice Training & Education	0	5,547	0	0	0	0	0	0	0	0	0	5,547	23
24	Travel and Seminar	0	573	0	0	0	0	0	0	0	0	0	573	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	0	32,732	0	0	0	0	0	0	0	0	32,732	27
28	TOTAL General Administration	(231,161)	379,111	(300,032)	8,029	0	(144,053)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(227,540)	379,503	(300,032)	8,029	0	(140,040)	29						

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare & Rehab# 0044859

Report Period Beginning:

1-Jan-2013 Ending:

Summary B

31-Dec-2013

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	144,168	3,289	0	397,215	0	0	0	0	0	0	0	544,672	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,642)	4,960	3,866	886,925	0	0	0	0	0	0	0	857,109	32
33	Real Estate Taxes	0	0	0	3,884	0	0	0	0	0	0	0	3,884	33
34	Rent-Facility & Grounds	0	0	0	(1,200,000)	0	0	0	0	0	0	0	(1,200,000)	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	105,526	8,249	3,866	88,024	0	205,665	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)	(122,014)	387,752	(296,166)	96,053	0	65,625	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	19 Professional Services	\$	Lancaster, Ltd.	100.00%	\$ 4,468	\$ 4,468	1
2	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	121,297	121,297	2
3	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	20,326	20,326	3
4	V	24 Seminars and Travel		Lancaster, Ltd.	100.00%	573	573	4
5	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	157,714	157,714	5
6	V	20 Marketing Fees		Lancaster, Ltd.	100.00%	67,636	67,636	6
7	V	20 Dues, Fees & Subscriptions		Lancaster, Ltd.	100.00%	1,550	1,550	7
8	V	30 Depreciation		Lancaster, Ltd.	100.00%	3,289	3,289	8
9	V	6 Repairs and Maintenance		Lancaster, Ltd.	100.00%	392	392	9
10	V	32 Interest Paid		Lancaster, Ltd.	100.00%	4,960	4,960	10
11	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	5,547	5,547	11
12	V							12
13	V							13
14	Total		\$			\$ 387,752	\$ * 387,752	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	17 Management Fee Income	\$ 453,600	Lancaster, Ltd.	100.00%	\$	\$ (453,600)
16	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	120,836	120,836
17	V	27 Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	5,934	5,934
18	V	27 Payroll Taxes-Staff		Lancaster, Ltd.	100.00%	26,798	26,798
19	V						
20	V						
21	V	32 **Direct Interest**		Lancaster, Ltd.		3,866	3,866
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		\$ 453,600			\$ 157,434	\$ * (296,166)

* 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			\$	\$ (1,200,000)
16	V	32 Interest				613,750	613,750
17	V	32 Interest				5,250	5,250
18	V	32 Mortgage Interest				267,159	267,159
19	V	30 Depreciation				397,215	397,215
20	V	33 Real Estate Tax				3,884	3,884
21	V	19 Professional Fees				8,029	8,029
22	V						
23	V	32 **Direct Interest**				766	766
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			\$ 1,296,053	\$ * 96,053

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

Facility Name & ID Number Wauconda Healthcare & Rehab # 0044859 Report Period Beginning: 1-Jan-2013 Ending: 31-Dec-2013

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	14.5	30.21	Lancaster	\$ 60,418	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	14.5	30.21	Lancaster	60,418	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	\$ 120,836		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 & Rehab

0044859

Report Period Beginning:

1-Jan-2013

Ending: -Dec-2013

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	4	\$ 200,004	\$ 200,004	15	\$ 60,418	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	9,821		15	2,967	2
3	17	Cheryl Morris	Hours Worked	48	4	200,004	200,004	15	60,418	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	9,821		15	2,967	4
5										5
6										6
7	19	Professional Services	Census Days	186,480	4	21,061		39,561	4,468	7
8	21	Clerical Expenses	Census Days	186,480	4	571,764	526,455	39,561	121,297	8
9	22	Employee Benefits	Census Days	186,480	4	95,812		39,561	20,326	9
10	24	Seminars and Travel	Census Days	186,480	4	2,703		39,561	573	10
11	17	Administrative Consulting	Census Days	186,480	4	743,420	743,420	39,561	157,714	11
12	20	Marketing Fees	Census Days	186,480	4	318,816	299,496	39,561	67,636	12
13	20	Dues, Fees and Subscriptions	Census Days	186,480	4	7,305		39,561	1,550	13
14	30	Depreciation	Census Days	186,480	4	15,502		39,561	3,289	14
15	6	Repairs and Maintenance	Census Days	186,480	4	1,847		39,561	392	15
16	27	Payroll Taxes	Census Days	186,480	4	126,320		39,561	26,798	16
17	32	Interest	Census Days	186,480	4	23,379		39,561	4,960	17
18	23	Education and Inservice	Census Days	186,480	4	26,147		39,561	5,547	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,373,726	\$ 1,969,379		\$ 541,320	25

Facility Name & ID Number

Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

1-Jan-2013

Ending:

31-Dec-2013

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	Name of Lender	2		3	4	5	6		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	\$29,401.20	Feb 2009	\$ 3,595,000	\$ 2,921,405	Jan 2029	9.0000	\$ 267,159						
2	Boehmer Automotive, Inc.		X	Land Purchase							5,250						
3																	
4																	
5																	
Working Capital																	
6	Harston Investments		X	Working Capital							613,750						
7	JP Morgan Chase Bank		X	Working Capital							4,960						
8																	
9	TOTAL Facility Related				\$29,401.20		\$ 3,595,000	\$ 2,921,405			\$ 891,119						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 3,595,000	\$ 2,921,405			\$ 891,119						

Less: Interest Income (34,010)

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

N/A

857,109

Page 4 Line 32 col. 8

* 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 2012 report.		\$	188,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	209,857		2
3. Under or (over) accrual (line 2 minus line 1).		\$	21,857		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	227,000		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.		\$	248,857		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	142,567	8	FOR BHF USE ONLY	
	2009	127,001	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13
	2010	152,728	10	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2011	178,810	11	15	LESS REFUND FROM LINE 6 \$ _____ 15
	2012	205,973	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
** Accrual is based on 2012 Taxes, adjusted for inflation**					

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wauconda Healthcare & 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 2012 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 2012.

(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>195,586.78</u>	\$ <u>195,586.78</u>
2. <u>09-35-200-059</u>	<u>Long-Term Healthcare</u>	\$ <u>10,073.20</u>	\$ <u>10,073.20</u>
3. <u>09-35-200-057</u>	<u>Long-Term Healthcare</u>	\$ <u>313.41</u>	\$ <u>313.41</u>
4. _____	_____	\$ _____	\$ _____
5. <u>09-35-200-010</u>	<u>Long-Term Healthcare</u>	\$ <u>3,884.00</u>	\$ _____
6. _____	<u>(Land for expansion)</u>	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>209,857.39</u></u>	\$ <u><u>205,973.39</u></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? X YES NO

If YES, attach an explanation and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

** Vacant Land was purchased next to the Facility with the explicit intention of expanding the Long Term Nursing Facility. A Certificate of Need (CON) has been obtained from the Health Facilities & Services Review Board, State of Illinois.

Page 10A

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).

 None

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>	1
2	<u>Land for Expansion</u>	<u>94,090</u>	<u>2012</u>	<u>479,811</u>	2
3	TOTALS	<u>249,722</u>		<u>\$ 868,811</u>	3

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

1-Jan-2013 Ending:

31-Dec-2013

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	135	2000		\$ 7,131,000	\$ 325,136	39	\$ 380,777	\$ 55,641	\$ 1,835,011	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Redwood Sign 4x6	2000		2,862	169	15	169		2,567	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		15	73	73	829	12
13	Construction of Dementia Unit	2006		2,288,579	58,679	20	114,429	55,750	867,753	13
14	Fittings & Fixtures to Dementia Unit	2006		130,960		5			130,960	14
15	Concrete Sidewalk	2006		7,050	416	15	470	54	3,563	15
16	Outside Landscaping	2006		19,800	1,168	15	1,320	152	10,010	16
17	New Brick Patio	2006		7,400	492	15	492		3,517	17
18	Dining Area Expansion, Nurses Station & Fitness Club	2007		196,512	5,039	20	9,826	4,787	63,869	18
19	Cabinetry & Lighting for above	2007		45,050		5			45,050	19
20	Renovation of Roof	2007		24,000		10	2,400	2,400	15,200	20
21	Preconstruction planning, Architectural & Auto CAD Work	2008		4,295	110	20	215	105	1,091	21
22	Demolition, Removal of Debris & Temporary Costructor	2008		3,500	90	20	175	85	892	22
23	Reconstruction of Dry Wall, Windows & Doors per Plan	2008		26,000	667	20	1,300	633	6,607	23
24	Installation of Suspended Ceiling & Electrical fitting/pipes	2008		5,000	128	20	250	122	1,270	24
25	Resurfacing of Parking Lot	2009		8,165	283	15	544	261	2,539	25
26	Fire Rated Door Frame & Fixtures	2009		1,870	48	10	187	139	826	26
27	Hot water heating Boiler	2009		11,500	295	10	1,150	855	4,983	27
28	Mirrored Walls, Windows & Tiles in Therapy Room	2009		16,748	429	10	1,675	1,246	7,956	28
29	4 Units of 120 Volts Electrical Panels in Nursing Stations	2010		12,500	321	10	1,250	929	4,063	29
30	Surveillance Camera Monitoring System in & around Facility	2012		9,990	1,598	7	1,427	(171)	2,616	30
31	Air conditioning Duct System in Hallways - 100,200,300 Wings	2012		14,600	374	10	1,460	1,086	2,312	31
32	Installation of DTV, Modulators,Dish Antenna & Cables	2012		10,103	1,616	5	2,021	405	2,695	32
33	Ceiling Mounted Hoyer Patient Lift System	2012		6,280	1,005	5	1,256	251	1,675	33
34	Roof Top HVAC with Heat Exchanger	2012		8,800	226	10	880	654	953	34
35	Remove & Install Carpet/Handrails/Cove/Wallpaper-100 Wing Corridor	2013		23,880	588	20	1,194	606	1,194	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 & Rehab

0044859

Report Period Beginning:

1-Jan-2013 Ending:

31-Dec-2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Cost of Cove,Corner Guards,Handrails,Art-100 Wing Corridor	2013	\$ 6,489	\$ 3,893	5	\$ 1,298	\$ (2,595)	\$ 1,298	37
38	Tiles/Ceiling/DryWall/Fittings/Shower Door-100 Wing Shower Rm	2013	30,342	747	20	1,517	770	1,517	38
39	Patient Hoyer Lift fixed on Ceiling	2013	6,280	3,768	5	1,151	(2,617)	1,151	39
40	Auto Door Operator for Front Entrance	2013	3,590	2,154	5	359	(1,795)	359	40
41	10 Ton Roof Top HVAC Unit	2013	7,800	92	10	390	298	390	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)		\$ 10,190,250	\$ 409,531		\$ 529,655	\$ 120,124	\$ 3,142,921	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 106,206	\$ 17,025	\$ 52,413	\$ 35,388		\$ 22,063	71
72	Current Year Purchases	32,410	19,446	3,428	(16,018)		3,428	72
73	Fully Depreciated Assets	731,937	2,131	6,805	4,674		731,937	73
74	**Lancaster Allocation**		3,289	3,289			27,458	74
75	TOTALS	\$ 870,553	\$ 41,891	\$ 65,935	\$ 24,044		\$ 784,886	75

D. Vehicle Costs. (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)	\$ 11,929,614	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 451,422	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 595,590	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 144,168	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,927,807	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning: 1-Jan-2013

Ending: 31-Dec-2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:	**Leased from a Related Entity**		\$			3
4	Additions						4
5	**Off-site Clerical Office**			45,558			5
6	***Off-site Vehicle Parking Space***			9,000			6
7	TOTAL			\$ 54,558			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 N/A.

None

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 21,540

Description: Rehabilitation Equipment @\$1,795 per month for 12 months

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 371,536	\$		\$ 371,536	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			126,120			126,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			634,732			634,732	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-3	hrs			4,327			4,327	8
9	Pharmacy		# of prescrpts				482,262		482,262	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					45,838		45,838	12
13	Other (specify): **Speciality Beds**	39-2					640		640	13
14	TOTAL			\$		\$ 1,136,715	\$ 528,740		\$ 1,665,455	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 & Rehab

0044859

Report Period Beginning: 1-Jan-2013

Ending:

31-Dec-2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2013 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 152,344	\$ 152,344	1
2	Cash-Patient Deposits	42,986	42,986	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,968,856	2,968,856	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,963	18,963	6
7	Other Prepaid Expenses	33,099	33,099	7
8	Accounts Receivable (owners or related parties)	1,259,640		8
9	Other(specify): **Refundable Deposits**	5,000	5,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,480,888	\$ 3,221,248	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		868,811	13
14	Buildings, at Historical Cost		7,131,000	14
15	Leasehold Improvements, at Historical Cost	247,794	3,035,251	15
16	Equipment, at Historical Cost	654,064	870,554	16
17	Accumulated Depreciation (book methods)	(781,392)	(3,721,812)	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**		530,279	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 120,466	\$ 8,714,083	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,601,354	\$ 11,935,331	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 353,589	\$ 353,589	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,986	42,986	28
29	Short-Term Notes Payable		2,453,768	29
30	Accrued Salaries Payable	506,502	506,502	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,866	54,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)	227,000	227,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,184,943	\$ 3,638,711	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)	\$ 1,184,943	\$ 8,138,711	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,416,411	\$ 3,796,620	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,601,354	\$ 11,935,331	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,282,105	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,282,105	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	134,306	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)	\$ 134,306	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)	\$ 3,416,411	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	\$ 3,008,367	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,008,367	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,253	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)	\$ 788,253	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)	\$ 3,796,620	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,422,027	1
2	Discounts and Allowances for all Levels	(5,073,592)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,348,435	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,761,250	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,761,250	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	482,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,089	19
20	Radiology and X-Ray	22,722	20
21	Other Medical Services	36,270	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 550,469	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	37,876	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,876	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)	\$ 11,698,030	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,881,268	31
32	Health Care	4,259,096	32
33	General Administration	1,932,277	33
B. Capital Expense			
34	Ownership	1,571,989	34
C. Ancillary Expense			
35	Special Cost Centers	1,665,455	35
36	Provider Participation Fee	73,912	36
D. Other Expenses (specify):			
37			37
38	**State Assessment Tax @\$6.07**	179,727	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,563,724	40
41	Income before Income Taxes (line 30 minus line 40)**	134,306	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 134,306	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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. **Set off on Pg 9 & 5**
 ****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning: 1-Jan-2013

Ending: 31-Dec-2013

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	1,681	2,092	\$ 78,085	\$ 37.33	1
2	Assistant Director of Nursing	2,021	2,214	87,889	39.70	2
3	Registered Nurses	34,164	37,857	1,114,209	29.43	3
4	Licensed Practical Nurses	14,857	15,927	374,740	23.53	4
5	CNAs & Orderlies	128,825	142,792	1,871,343	13.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,880	2,276	35,962	15.80	9
10	Activity Assistants	3,760	4,140	44,327	10.71	10
11	Social Service Workers	4,450	4,984	75,672	15.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,866	33,424	401,068	12.00	15
16	Dishwashers					16
17	Maintenance Workers	2,961	3,313	49,797	15.03	17
18	Housekeepers	30,166	33,149	323,791	9.77	18
19	Laundry	5,379	6,551	66,986	10.23	19
20	Administrator	2,176	2,545	70,854	27.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,672	13,940	209,265	15.01	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	1,884	2,094	39,336	18.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	277,742	307,298	\$ 4,843,324 *	\$ 15.76	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	617	\$ 17,293	1-3	35
36	Medical Director	5,475	21,900	9-3	36
37	Medical Records Consultant	174	4,512	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	294	7,918	10-3	39
40	Physical Therapy Consultant	1,000	27,998	10a-3	40
41	Occupational Therapy Consultant	640	17,904	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	253	7,357	10a-3	43
44	Activity Consultant			11-3	44
45	Social Service Consultant	221	5,760	12-3	45
46	Other(specify)				46
47	** Dementia Consultant **	130	3,550	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	8,804	\$ 114,192		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,405	\$ 99,558	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,405	\$ 99,558		53

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	
													Amount of Expense Amortized Per Year
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1	Painting & Decorating	Mar-2004	\$ 1,000	3	\$ 167								
2	Painting & Decorating	Apr-2004	2,000	3	333								
3	Painting & Decorating	Apr-2004	5,515	3	920								
4	Painting & Decorating	Sep-2005	1,532	3	510	256							
5	Painting & Decorating	Jul-2006	6,246	3	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	Painting & Decorating	Aug-2010	2,739	3				456	913	913	457		
10	Painting & Decorating	Mar-2011	3,953	3					1,318	1,317	1,318		
11	Painting & Decorating	Oct-2011	3,296	3					549	1,099	1,099	549	
12	Painting & Decorating	Mar-2012	9,477	3						3,159	3,159	3,159	
13	Painting & Decorating	Jun-2013	2,422	3							807	808	807
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 47,262		\$ 5,082	\$ 4,946	\$ 3,861	\$ 2,406	\$ 3,202	\$ 6,700	\$ 6,840	\$ 4,516	\$ 807

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? 12 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,342 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. \$ 73,912
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. \$ 23,842 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? Yes (details on Page 24)
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. \$ None
 - 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. \$ None
- (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.

Details of Out-of-State Travel for Page 21 Schedule G

Out of State travel on 4 occasions was undertaken by the Food Director for specific purposes defined below

<u>Date of Travel</u>	<u>Travel to</u>	<u>State</u>	<u>Purpose</u>	<u>Amount</u>
1-Feb-13	Milwaukee	Wisconsin	To attend a workshop organized by Direct Supply, showcasing Dietary/Kitchen Equipment	69.56
18-Mar-13	Milwaukee	Wisconsin	To attend a Food Show hosted by one of the leading Food Vendors	52.80
21-Oct-13	Davenport	Iowa	To attend a Seminar/Food Show hosted by Thoms Proestler, our food Vendor	178.96
30-Oct-13	Milwaukee	Wisconsin	To attend a Seminar/Food Show hosted by Gordon Food Service, our food Vendor	64.52
				\$365.84

Rounded off to **\$366**

Reflected on page 21, Schedule G, Row 1