

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 N/A

	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>135</u>	Skilled (SNF)	<u>135</u>	<u>49,275</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>135</u>	TOTALS	<u>135</u>	<u>49,275</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>35</u>	<u>693</u>	<u>11,257</u>	<u>11,985</u>	8
9	SNF/PED					9
10	ICF	<u>14,787</u>	<u>6,462</u>	<u>206</u>	<u>21,455</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,822</u>	<u>7,155</u>	<u>11,463</u>	<u>33,440</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.86%

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 5/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2000 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 9,622

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	325,538	52,310	17,698	395,546		395,546		395,546		1
2	Food Purchase		245,685		245,685		245,685	(1,039)	244,646		2
3	Housekeeping	345,425	214		345,639		345,639		345,639		3
4	Laundry	32,808	17,782	10,187	60,777		60,777		60,777		4
5	Heat and Other Utilities			183,440	183,440		183,440	(4,928)	178,512		5
6	Maintenance	65,965	66,111	279,325	411,401		411,401	(17,459)	393,942		6
7	Other (specify):*										7
8	TOTAL General Services	769,736	382,102	490,650	1,642,488		1,642,488	(23,426)	1,619,062		8
	B. Health Care and Programs										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	3,647,138	290,858	13,000	3,950,996		3,950,996		3,950,996		10
10a	Therapy	291,607	62		291,669		291,669		291,669		10a
11	Activities	39,417	47,287		86,704		86,704		86,704		11
12	Social Services	105,733	15,327	10,086	131,146		131,146		131,146		12
13	CNA Training										13
14	Program Transportation			509	509		509		509		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,083,895	353,534	61,995	4,499,424		4,499,424		4,499,424		16
	C. General Administration										
17	Administrative	76,196		664,200	740,396		740,396	(321,442)	418,954		17
18	Directors Fees										18
19	Professional Services			53,315	53,315		53,315	2,751	56,066		19
20	Dues, Fees, Subscriptions & Promotions			119,019	119,019		119,019	(87,575)	31,444		20
21	Clerical & General Office Expenses	191,518	77,448	195,244	464,210		464,210	(10,213)	453,997		21
22	Employee Benefits & Payroll Taxes			1,028,022	1,028,022		1,028,022		1,028,022		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,445	3,445		3,445	11,730	15,175		24
25	Other Admin. Staff Transportation			1,860	1,860		1,860		1,860		25
26	Insurance-Prop.Liab.Malpractice			129,560	129,560		129,560	511	130,071		26
27	Other (specify):*							56,187	56,187		27
28	TOTAL General Administration	267,714	77,448	2,194,665	2,539,827		2,539,827	(348,051)	2,191,776		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,121,345	813,084	2,747,310	8,681,739		8,681,739	(371,477)	8,310,262		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:

01/01/15

Ending:

12/31/15

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			41,128	41,128		41,128	399,870	440,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							679,668	679,668			32
33	Real Estate Taxes			222,765	222,765		222,765	11,173	233,938			33
34	Rent-Facility & Grounds			1,262,696	1,262,696		1,262,696	(1,262,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,526,589	1,526,589		1,526,589	(171,985)	1,354,604			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		638,473	1,112,425	1,750,898		1,750,898		1,750,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,325	218,325		218,325		218,325			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		638,473	1,330,750	1,969,223		1,969,223		1,969,223			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,121,345	1,451,557	5,604,649	12,177,551		12,177,551	(543,462)	11,634,089			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	(4,928)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	33,080	30		9
10	Interest and Other Investment Income	(1,490)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(524)	02		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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(134,777)	21		24
25	Fund Raising, Advertising and Promotional	(89,154)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(139,638)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (337,430)		\$	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)	(206,032)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (206,032)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (543,462)		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 & Rehab

ID# 0044859

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Commissions	\$ (515)	02	1
2	Bank Charges	(4,195)	21	2
3	Legal Fees - Collections	(13,204)	21	3
4	Building Co - License and Fees	(250)	20	4
5	Building Co - Accounting	(1,800)	19	5
6	Deferred Maintenance Cost (allocated for 2013)	807	06	6
7	Additional R&M	3,619	06	7
8	Capitalized R&M	(22,449)	06	8
9	Non-Allowable Marketing	(101,650)	43	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	(139,638)		49

Wauconda Healthcare & Rehab

ID# 0044859
 Report Period Beginning: 01/01/15
 Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare & Rehab# 0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

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													1
2	Food Purchase	(1,039)											(1,039)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,928)											(4,928)	5
6	Maintenance	(18,023)		564									(17,459)	6
7	Other (specify):*													7
8	TOTAL General Services	(23,990)		564									(23,426)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(321,442)									(321,442)	17
18	Directors Fees													18
19	Professional Services	(1,800)	1,800	2,751									2,751	19
20	Fees, Subscriptions & Promotions	(89,404)	250	1,579									(87,575)	20
21	Clerical & General Office Expenses	(152,176)		141,963									(10,213)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			11,730									11,730	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			511									511	26
27	Other (specify):*			56,187									56,187	27
28	TOTAL General Administration	(243,380)	2,050	(106,721)									(348,051)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(267,370)	2,050	(106,157)									(371,477)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	33,080	363,403	3,387									399,870	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,490)	645,586	35,572									679,668	32
33	Real Estate Taxes		11,173										11,173	33
34	Rent-Facility & Grounds		(1,262,696)										(1,262,696)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	31,590	(242,534)	38,959									(171,985)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(101,650)		101,650										43
44	TOTAL Special Cost Centers	(101,650)		101,650										44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(337,430)	(240,484)	34,452									(543,462)	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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	34 Rent	\$ 1,262,696	Wauconda Associates	100.00%	\$	(1,262,696)	1
2	V	32 Interest		Wauconda Associates	100.00%	645,586	645,586	2
3	V	30 Depreciation		Wauconda Associates	100.00%	363,403	363,403	3
4	V	20 License and Fees		Wauconda Associates	100.00%	250	250	4
5	V	19 Accounting		Wauconda Associates	100.00%	1,800	1,800	5
6	V	33 Real Estate Tax		Wauconda Associates	100.00%	11,173	11,173	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,262,696			\$ 1,022,212	\$ * (240,484)	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	19 Professional Services	\$	Lancaster, LTD	100.00%	\$ 2,751	\$ 2,751
16	V	21 Clerical Expenditures		Lancaster, LTD	100.00%	141,963	141,963
17	V	27 Employee Benefits		Lancaster, LTD	100.00%	11,940	11,940
18	V	24 Seminar and Travel		Lancaster, LTD	100.00%	10,025	10,025
19	V	17 Administrative Consulting		Lancaster, LTD	100.00%	223,311	223,311
20	V	43 Marketing Fees		Lancaster, LTD	100.00%	101,650	101,650
21	V	20 Dues, Fees and Subscriptions		Lancaster, LTD	100.00%	1,579	1,579
22	V	30 Depreciation		Lancaster, LTD	100.00%	3,387	3,387
23	V	06 Repairs and Maintenance		Lancaster, LTD	100.00%	564	564
24	V	27 Payroll Taxes		Lancaster, LTD	100.00%	37,178	37,178
25	V	32 Interest		Lancaster, LTD	100.00%	35,572	35,572
26	V	24 Education		Lancaster, LTD	100.00%	1,705	1,705
27	V	26 Insurance		Lancaster, LTD	100.00%	511	511
28	V						
29	V	17 Officer's Salaries		Lancaster, LTD	100.00%	119,447	119,447
30	V	27 Payroll Taxes - Officers		Lancaster, LTD	100.00%	7,069	7,069
31	V	17 Management Fees	664,200	Lancaster, LTD	100.00%		(664,200)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 664,200			\$ 698,652	\$ * 34,452

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Wauconda Healthcare & Rehab # 0044859 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	3	\$ 200,004	\$ 200,004	16	\$ 66,668	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	3	10,918		16	3,639	2
3	17	Cheryl Morris	Hours Worked	48	3	158,337	158,337	16	52,779	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	3	10,291		16	3,430	4
5										5
6	19	Professional Services	Census Days	118,590	3	9,757		33,440	2,751	6
7	21	Clerical Expenditures	Census Days	118,590	3	503,450	440,712	33,440	141,963	7
8	27	Employee Benefits	Census Days	118,590	3	42,342		33,440	11,940	8
9	24	Seminar and Travel	Census Days	118,590	3	35,553		33,440	10,025	9
10	17	Administrative Consulting	Census Days	118,590	3	791,941	791,941	33,440	223,311	10
11	43	Marketing Fees	Census Days	118,590	3	360,485	331,141	33,440	101,650	11
12	20	Dues, Fees and Subscriptions	Census Days	118,590	3	5,601		33,440	1,579	12
13	30	Depreciation	Census Days	118,590	3	12,013		33,440	3,387	13
14	6	Repairs and Maintenance	Census Days	118,590	3	1,999		33,440	564	14
15	27	Payroll Taxes	Census Days	118,590	3	131,845		33,440	37,178	15
16	32	Interest	Census Days	118,590	3	126,152		33,440	35,572	16
17	24	Education	Census Days	118,590	3	6,047		33,440	1,705	17
18	26	Insurance	Census Days	118,590	3	1,812		33,440	511	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,408,547	\$ 1,922,135		\$ 698,652	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle National Trust, N.A.		X	Mortgage	\$29,401.20	2/2009	\$ 3,595,000	\$ 2,725,236	1/2029	9.000%	\$ 250,336	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Harston Investment		X	Working Capital				4,500,000			393,750	6								
7	JP Morgan Chase Bank		X	Working Capital				300,000			1,500	7								
8	See Supplemental Schedule							750,000			35,572	8								
9	TOTAL Facility Related				\$29,401.20		\$ 3,595,000	\$ 8,275,236			\$ 681,158	9								
B. Non-Facility Related*																				
10	Interest Income		X								(1,490)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (1,490)	14								
15	TOTALS (line 9+line14)						\$ 3,595,000	\$ 8,275,236			\$ 679,668	15								

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

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

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

Facility Name & ID Number

Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	Shareholder Loan		X			\$	\$ 750,000			\$	8							
9	Allocated from Lancaster LTD		X								35,572							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2014 report.		\$	220,000	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.)		\$	229,937	2
3. Under or (over) accrual (line 2 minus line 1).		\$	9,937	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	224,000	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.		\$	233,937	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2010	<u>152,728</u>	8	
	2011	<u>178,810</u>	9	
	2012	<u>205,973</u>	10	
	2013	<u>212,858</u>	11	
	2014	<u>229,937</u>	12	
2015 Accrual = \$229,937 x 0.97 = \$224,000 (Rounded)				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wauconda Healthcare & Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>207,732.97</u>	\$ <u>207,732.97</u>
2. <u>09-35-200-059</u>	<u>Long Term Healthcare</u>	\$ <u>10,698.74</u>	\$ <u>10,698.74</u>
3. <u>09-35-200-057</u>	<u>Long Term Healthcare</u>	\$ <u>332.89</u>	\$ <u>332.89</u>
4. <u>09-35-200-010</u>	<u>Long Term Healthcare</u>	\$ <u>4,124.94</u>	\$ <u>4,124.94</u>
5. <u>09-23-300-041</u>	<u>Long Term Healthcare</u>	\$ <u>7,047.92</u>	\$ <u>7,047.92</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>229,937.46</u>	\$ <u>229,937.46</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,038 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>155,632</u>	<u>2009</u>	<u>\$ 389,000</u>	<u>1</u>
2	<u>Land for Expansion</u>	<u>94,090</u>	<u>2012</u>	<u>479,811</u>	<u>2</u>
3	TOTALS	<u>249,722</u>		<u>\$ 868,811</u>	<u>3</u>

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	2009	1970	\$ 7,131,000	\$ 363,403	39	\$ 182,846	\$ (180,557)	\$ 2,211,557	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2000	2,862		20	126	126	2,862	9
10	Various		2001	117,387		20			117,387	10
11	Various		2002	1,100		20	73	73	975	11
12	Various		2005	2,360,516		20	116,711	116,711	1,155,952	12
13	Various		2007	265,562		20	12,226	12,226	148,571	13
14	Various		2008	38,795		20	1,940	1,940	13,740	14
15	Various		2009	38,283		20	3,556	3,556	23,416	15
16	Various		2010	12,500		20	1,250	1,250	6,563	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

*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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		13,730			687	687	687	67
68								68
69			41,128			(41,128)		69
70		\$ 9,981,735	\$ 404,531		\$ 319,415	\$ (85,116)	\$ 3,681,710	70

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

Facility Name & ID Number Wauconda Healthcare & Rehab# 0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15**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	
1	Totals from Page 12A, Carried Forward		\$ 9,981,735	\$ 404,531		\$ 319,415	\$ (85,116)	\$ 3,681,710	1
2	Surveillance Camera Monitoring System In & Around Facility	2012	9,990		20	1,427	1,427	5,470	2
3	Air Conditioning Duct System In Hallways- 100,200,300 Wings	2012	14,600		20	1,460	1,460	5,232	3
4	Installation Of Dtv, Modulators, Dish Antenna & Cables	2012	10,103		20	2,021	2,021	6,737	4
5	Ceiling Mounted Hoyer Patient Lift System	2012	6,280		20	1,256	1,256	4,187	5
6	Roof Top Hvac With Heat Exchanger	2012	8,800		20	880	880	2,713	6
7	Remove&Install Carpet/Handrails/Cove/Wallpaper-100 Wing Cor	2013	23,880		20	1,194	1,194	3,582	7
8	Cove, Corner Guards, Handrails, Art - 100 Wing Corridor	2013	6,489		20	1,298	1,298	3,894	8
9	Tiles/Ceiling/Drywall/Fitting/Shower Door-100 Wing Shower Room	2013	30,342		20	1,517	1,517	4,551	9
10	Patient Hoyer Lift Fixed On Ceiling	2013	6,280		20	1,256	1,256	3,663	10
11	Auto Door Operator For Front Entrance	2013	3,590		20	718	718	1,795	11
12	10 Ton Roof Top Hvac Unit	2013	7,800		20	780	780	1,950	12
13	New Roof Top Hvac Unit	2014	7,100		20	710	710	1,183	13
14	Remodel Hall By Replacing Drywall & Repainting	2014	15,500		20	1,550	1,550	2,067	14
15	250 Point Fire Alarm Control Panel	2014	9,609		20	961	961	1,041	15
16	Prep Town Square-Remove Walls,Floors,Ceiling,Molding,Lights	2014	90,131		20	3,277	3,277	6,845	16
17	Carpet,Vinyl,Cove,Wallpaper,Mural,Ceiling,Lights-Town Square	2014	42,168		20	8,434	8,434	15,462	17
18	Wall Panels, Charting Unit, Lights, Planters For Nurses Station	2014	17,594		20	3,519	3,519	6,451	18
19	Carpet, Cabinet, Quartz Top, Accessories For Doctor'S Office	2014	11,901		20	2,380	2,380	4,364	19
20	Kitchen Cabinets, Quartz Top, Decorative Lights For Kitchen	2014	13,610		20	2,722	2,722	4,990	20
21	Library Unit, Table,Chairs,Seats,Lights,Waterfall-Living Room	2014	23,863		20	4,773	4,773	8,750	21
22	Wall,Floor Tile,Mirror & Light Fixtures For Bathroom	2014	1,130		20	41	41	86	22
23	Remove/Install Carpet,Trim,Paint,Stain Doors-200W Corridor	2014	33,351		20	6,670	6,670	12,229	23
24	Install New Carpet,Corner Guards,Sconces,Art For 100W Corridor	2014	8,859		20	1,772	1,772	3,249	24
25	Remove Wallpaper,Paint Wall/Trim,Stain Door,Cove-400 Wing	2014	30,039		20	6,008	6,008	11,015	25
26	Remove & Install Carpet & Millwork Cove For Offices	2014	6,045		20	1,209	1,209	2,217	26
27	Replace Ceiling, Prep Walls & Paint Rooms In 100 Wing	2014	9,851		20	358	358	748	27
28	Replace Tiles,Fixtures,Prep Walls&Paint Bathrooms In 100W Wing	2014	10,149		20	369	369	770	28
29	Hallway Cove Base And Crown Molding	2015	19,500		20	975	975	975	29
30	New Electric Panel	2015	3,750		20	188	188	188	30
31	Water Tank Installation	2015	2,563		20	128	128	128	31
32	100 & 300 Wing Exterior Exit - New Doors	2015	9,236		20	462	462	462	32
33	Install Sub Panel For Generator & Lines For Freezer/Cooler	2015	3,280		20	164	164	164	33
34	TOTAL (lines 1 thru 33)		\$ 10,479,118	\$ 404,531		\$ 379,891	\$ (24,640)	\$ 3,808,867	34

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,479,118	\$ 404,531		\$ 379,891	\$ (24,640)	\$ 3,808,867	1
2	Install Sub Panel For Motor Loads, Line For Nac Panel, Reroute C	2015	4,325		20	216	216	216	2
3	Roof Repair	2015	3,045		20	152	152	152	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	TOTAL (lines 1 thru 33)		\$ 10,486,488	\$ 404,531		\$ 380,259	\$ (24,272)	\$ 3,809,236	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 10,486,488	\$ 404,531		\$ 380,259	\$ (24,272)	\$ 3,809,236	1
2								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		\$ 10,486,488	\$ 404,531		\$ 380,259	\$ (24,272)	\$ 3,809,236	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 10,486,488	\$ 404,531		\$ 380,259	\$ (24,272)	\$ 3,809,236	1
2								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		\$ 10,486,488	\$ 404,531		\$ 380,259	\$ (24,272)	\$ 3,809,236	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Hallway Trim Work on Frames and Doors	2015	13,730		20	687	687	687	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	TOTAL (lines 1 thru 33)		\$ 13,730	\$		\$ 687	\$ 687	\$ 687	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
1		\$ 13,730	\$		\$ 687	\$ 687	\$ 687
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 13,730	\$		\$ 687	\$ 687	\$ 687

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

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	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
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20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

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

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 489,081	\$ 3,387	\$ 58,920	\$ 55,533	10	\$ 179,398	71
72	Current Year Purchases	18,185		1,819	1,819	10	1,819	72
73	Fully Depreciated Assets	824,947				10	824,947	73
74								74
75	TOTALS	\$ 1,332,213	\$ 3,387	\$ 60,739	\$ 57,352		\$ 1,006,164	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)	\$ 12,687,511	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 407,918	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 440,998	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 33,080	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,815,399	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	Construction in Progress	\$ 437,632	92
93			93
94			94
95		\$ 437,632	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			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: _____ *

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 _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost													
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	425,115	\$			\$	425,115			1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					121,321							121,321		2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs					565,324							565,324		4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	39 - 02	# of prescripts								550,946				550,946		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify): <u>See Supplemental</u>							665			87,527				88,192		13
14	TOTAL			\$				\$	1,112,425	\$	638,473			\$	1,750,898		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: **01/01/15**

Ending: **12/31/15**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/15** (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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,187,533	2,187,533	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	95,046	95,046	7
8	Accounts Receivable (owners or related parties)	123,789	123,789	8
9	Other(specify):	3,075	3,075	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,409,443	\$ 2,409,443	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		6,211,911	14
15	Leasehold Improvements, at Historical Cost	303,253	4,403,131	15
16	Equipment, at Historical Cost	687,821	965,321	16
17	Accumulated Depreciation (book methods)	(891,922)	(5,392,536)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		437,632	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 99,152	\$ 7,494,270	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,508,595	\$ 9,903,713	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 592,999	\$ 592,998	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,016	42,016	28
29	Short-Term Notes Payable	300,000	4,800,000	29
30	Accrued Salaries Payable	526,113	526,113	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,787	14,787	31
32	Accrued Real Estate Taxes(Sch.IX-B)	224,000	224,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36			223,789	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,699,915	\$ 6,423,703	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,475,236	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)	\$	\$ 3,475,236	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,699,915	\$ 9,898,939	46
47	TOTAL EQUITY(page 18, line 24)	\$ 808,680	\$ 4,774	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,508,595	\$ 9,903,713	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,376,623	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,376,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,567,942)	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)	\$ (1,567,942)	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)	\$ 808,680	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Healthcare & Rehab

0044859

Report Period Beginning: 01/01/15

Ending:

12/31/15

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	\$ 12,184,445	1
2	Discounts and Allowances for all Levels	(5,137,120)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,047,325	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,905,207	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,905,207	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	572,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,327	19
20	Radiology and X-Ray	42,762	20
21	Other Medical Services	27,375	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 655,072	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,490	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,490	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	515	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 515	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,609,609	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,642,488	31
32	Health Care	4,499,424	32
33	General Administration	2,539,827	33
B. Capital Expense			
34	Ownership	1,526,589	34
C. Ancillary Expense			
35	Special Cost Centers	1,750,898	35
36	Provider Participation Fee	218,325	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,177,551	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,567,942)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,567,942)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,443,484	44
45	Private Pay - Net Inpatient Revenue	1,833,286	45
46	Medicare - Net Inpatient Revenue	2,203,299	46
47	Other-(specify) <u>Insurance</u>	567,256	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,047,325	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number **Wauconda Healthcare & Rehab**

0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,874	2,126	\$ 95,880	\$ 45.10	1
2	Assistant Director of Nursing	1,258	1,277	47,151	36.92	2
3	Registered Nurses	39,601	43,615	1,492,591	34.22	3
4	Licensed Practical Nurses	13,348	14,374	453,973	31.58	4
5	CNAs & Orderlies	102,505	113,502	1,517,308	13.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,643	20,264	291,607	14.39	8
9	Activity Director	1,647	1,956	29,539	15.10	9
10	Activity Assistants	795	821	9,878	12.03	10
11	Social Service Workers	5,179	5,785	105,733	18.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,324	9,334	145,438	15.58	14
15	Cook Helpers/Assistants	15,864	17,585	180,100	10.24	15
16	Dishwashers					16
17	Maintenance Workers	3,861	4,255	65,965	15.50	17
18	Housekeepers	31,723	34,230	345,425	10.09	18
19	Laundry	2,794	3,103	32,808	10.57	19
20	Administrator	1,864	2,166	76,196	35.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,996	12,325	191,518	15.54	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	1,838	2,086	40,235	19.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	262,114	288,804	\$ 5,121,345 *	\$ 17.73	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	631	\$ 17,698	01-03	35
36	Medical Director	960	38,400	09-03	36
37	Medical Records Consultant	197	4,896	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	312	8,104	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	458	10,086	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,558	\$ 79,184		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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	
Cheryl Hahn	Administrator	0.00%	\$ 76,196	Workers' Compensation Insurance	\$ 119,500	IDPH License Fee	\$ 3,420	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,495	
				FICA Taxes	391,045	Health Care Worker Background Check	1,785	
				Employee Health Insurance	451,319	(Indicate # of checks performed <u>22</u>)		
				Employee Meals		Patient Background Checks	<u>725</u> 8,410	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	7,710	
				Retirement Plan	53,228	License and Fees	4,045	
				Other Employee Benefits	12,929	Allocated from Lancaster LTD	1,579	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,196	TOTAL (agree to Schedule V, line 22, col.8)		\$ 31,443		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees - Lancaster, LTD			\$ 664,200				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 664,200	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee		Type	Amount	Description	Line #	Amount	Description	Amount
FR&R/Marcum LLP		Accounting	\$ 4,600				Out-of-State Travel	\$
Richard Peelo & Associates		Accounting	2,250					
Health Data Systems		Data Processing	7,649				In-State Travel	
E-Health Solutions		Data Processing	30,979					
See Attached		Legal	6,931				Seminar Expense	3,445
Personnel Planners		Payroll Tax Consultant	905				Allocated from Lancaster LTD	11,730
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 53,315	TOTAL		\$	Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 15,175

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting and Decorating	Jun - 2013	\$ 2,422	3	\$	\$	\$	\$	\$	\$ 807	\$ 807	\$ 807
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 2,422		\$	\$	\$	\$	\$	\$ 807	\$ 807	\$ 807

Facility Name & ID Number Wauconda Healthcare & Rehab# 0044859

Report Period Beginning:

01/01/15

Ending:

12/31/15**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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,136 Line 10-02
- (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. \$ 218,325
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. \$ No 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
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? 100% Ln 14
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.