

ORIGINAL

ORIGINAL SIGNATURES

12-062

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT- May 2010 Edition

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

RECEIVED

JUN 27 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

HEALTH FACILITIES &
SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Wauconda Healthcare and Rehabilitation Centre		
Street Address: 176 Thomas Court		
City and Zip Code: Wauconda 60084		
County: Lake	Health Service Area: VIII	Health Planning Area: 097

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Wauconda Associates, LLC	
Address: 176 Thomas Court, Wauconda, Illinois 60084	
Name of Registered Agent: Laurence Zung	
Name of Chief Executive Officer: Laura Zung	
CEO Address: 5061 North Pulaski Road, Chicago, Illinois 60630	
Telephone Number: (561) 723-0139	

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Charles H. Foley
Title: Health Care Consultant
Company Name: Charles H. Foley & Associates, Inc.
Address: 1638 South MacArthur Boulevard, Springfield, Illinois 62704
Telephone Number: (217) 544-1551
E-mail Address: foley.associates@sbcglobal.net
Fax Number: (217) 544-3615

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Christopher Vicere
Title: Vice President - Finance
Company Name: Lancaster Health Group
Address: 5061 North Pulaski, Chicago, Illinois 60630
Telephone Number: (773) 604-4416
E-mail Address: cvicere@Lancaster-hq.com
Fax Number: (773) 478-1192

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

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Fax Number: (773) 478-1192

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960

Name: Margaret Ryan
Title: Administrator
Company Name: Wauconda Healthcare and Rehab Centre
Address: 176 Thomas Court, Wauconda, Illinois 60084
Telephone Number: (847) 526-5551
E-mail Address: mryan@lancastrhealthgroup.com
Fax Number: (847) 526-7549

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Wauconda Associates, LLC
Address of Site Owner: 176 Thomas Court, Wauconda, Illinois 60084
Street Address or Legal Description of Site: 176 Thomas Court, Wauconda, Illinois 60084 Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Wauconda Healthcare and Rehabilitation Centre, LLC
Address: 176 Thomas Court, Wauconda, Illinois 60084
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
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Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT 5 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

<p>Part 1110 Classification:</p> <p><input checked="" type="checkbox"/> Substantive</p> <p><input type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input checked="" type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The Applicant of Wauconda Health Care and Rehabilitation Centre is Wauconda Healthcare and Rehabilitation Centre, LLC (operator/Licensee) and Wauconda Associates, LLC. (owner). This existing single story 135-bed nursing facility with a partial basement located at 176 Thomas Court, Wauconda, Illinois 60084.

The proposed project is for the modernization of the existing facility that will result in the replacement and addition of beds. Specifically, this project will add 57 newly constructed private bed rooms of which 17 will provide replacement beds (15 will replace an existing 15 double room wing which will be turned into private rooms and two three bedroom ward rooms that will be used as semi-private room accommodations). The balance of 40 beds will be in addition to the existing licensed capacity of 135 bringing the proposed licensed capacity to 175. In addition to the new construction of resident rooms, the addition will include 41,979 gross square foot single story structure on to the existing 38,899 gross square feet building. It will include: a new and expanded therapy department; a consolidation of the administration space, employee and new employee training space; a new main entrance; and a covered ambulance entrance. The renovations to the existing space include; the expansion and modernizations of the existing kitchen and dining areas; and the conversion of space into a bistro, library, game area, coffee and juice bar, and a computer café; and the reduction of beds within the rooms as outlined above to improve the overall number of private rooms in the facility. Renovated space will encompass 6,023 gross square feet of the existing space. Upon project completion the facility will have 80,878 gross square feet with 73 private rooms and 51 semi-private rooms as compared to its current compliment of 1 private, 2-3 bed ward rooms and 64-double bedrooms.

This project is considered Substantive in accordance with the rules of 77 Illinois Administrative Code, Part 1110 of Subpart A, Section 1110.40.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	19,800	10,200	30,000
Site Survey and Soil Investigation	11,880	6,120	18,000
Site Preparation	55,440	28,560	84,000
Off Site Work	0	0	
New Construction Contracts	4,796,484	2,470,916	7,267,400
Modernization Contracts	448,948	231,275	680,221
Contingencies	541,659	279,036	820,695
Architectural/Engineering Fees	280,304	134,096	394,400
Consulting and Other Fees	99,000	51,000	150,000
Movable or Other Equipment (not in construction contracts)	290,917	149,867	440,784
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	0	0	0
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	0	0	0
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	6,524,430	3,361,070	9,885,500
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	6,524,430	3,361,070	9,885,500
Pledges	0	0	0
Gifts and Bequests	0	0	0
Bond Issues (project related)	0	0	0
Mortgages	0	0	0
Leases (fair market value)	0	0	0
Governmental Appropriations	0	0	0
Grants	0	0	0
Other Funds and Sources	0	0	0
TOTAL SOURCES OF FUNDS	6,524,430	3,361,070	9,885,500

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Purchase Price:	\$ <u>465,750</u>	
Fair Market Value:	\$ <u>465,750</u>	
The project involves the establishment of a new facility or a new category of service		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>0</u> .		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input checked="" type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>May 2014</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input checked="" type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENTS, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals

Are the following submittals up to date as applicable:
<input type="checkbox"/> Cancer Registry
<input type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input type="checkbox"/> All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

New Construction	Cost (\$)	Gross Square Feet		Amount of Proposed Total Gross Square Feet that is:			
		Existing	Proposed	New Construction	Modernized	As is	Vacated Space
CLINICAL							
Patient Rooms	\$3,501,568	13,600	28,648	15,048	-	13,600	-
Patient Bathrooms	\$ 506,510	1,579	4,144	2,565	-	1,579	-
Nurses Station/Med Prep	\$ 229,787	615	1,880	1,265	-	615	-
LR/DR/Activity	\$1,443,138	8,592	11,807	3,215	4,100	4,492	-
Exam Room	\$ -	-	-	-	-	-	-
Kitchen/Food Svc	\$ 165,129	723	1,351	628	723	-	-
PT/OT	\$ 366,682	-	3,000	3,000	-	-	-
Laundry	\$ 89,226	730	730	-	-	730	-
Janitor Closet	\$ 15,278	50	125	75	-	50	-
Clean/Soiled Linen	\$ 61,114	300	500	200	-	300	-
Beauty/Barber	\$ 97,782	150	800	650	-	150	-
Total CLINICAL	\$6,476,214	26,339	52,985	26,648	4,823	21,516	-
NON CLINICAL							
Office/Admin	\$ 283,346	1,200	2,400	1,200	1,200	-	-
Kitchen	\$ -	-	-	-	-	-	-
EE Lounge	\$ 67,225	550	550	-	-	550	-
Locker, Training	\$ -	-	-	-	-	-	-
Mechanical	\$ 103,883	-	850	850	-	-	-
Lobby	\$ 137,506	450	1,125	675	-	450	-
Storage/Maint	\$ 266,456	1,610	2,180	570	-	1,610	-
Corridor/Public Toilet	\$2,051,952	6,750	16,788	10,038	-	6,750	-
Structure/Misc	\$ 488,909	2,000	4,000	2,000	-	2,000	-
Total NON CLINICAL	\$3,409,286	12,560	27,893	15,333	1,200	11,360	-
TOTAL	\$9,885,500	38,899	80,878	41,979	6,023	32,876	-

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service. Any bed capacity discrepancy from the Inventory will result in the application being deemed incomplete.

FACILITY NAME: Wauconda Healthcare & Rehabilitation Center		CITY: Wauconda			
REPORTING PERIOD DATES: From: March 2011 to: February 2012					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	135	510	44,034	+57-15-2 Net +40	175
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	135	510	44,034	+57-15-2 Net +40	175

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

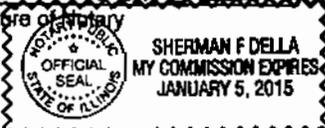
This Application for Permit is filed on the behalf of Wauconda Associates, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Laurence Zung
 SIGNATURE
LAURENCE ZUNG
 PRINTED NAME
DIRECTOR
 PRINTED TITLE

Christopher Vicere
 SIGNATURE
CHRISTOPHER VICERE
 PRINTED NAME
VP-FINANCE
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15 day of MARCH, 2012

Notarization:
Subscribed and sworn to before me
this 15 day of MARCH, 2012

Signature of Notary

 Seal

Signature of Notary

 Seal

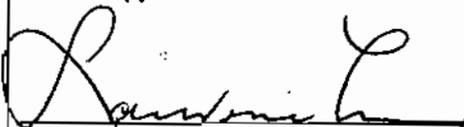
*Insert EXACT legal name of the applicant

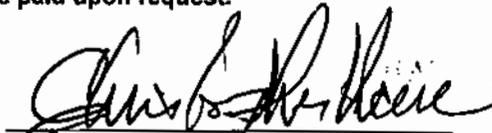
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- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

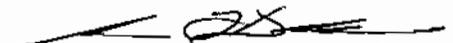
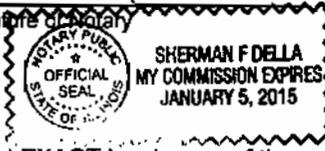
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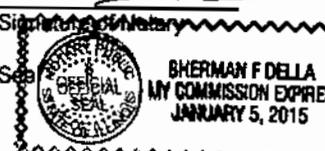

 SIGNATURE
LAURENCE ZUNG
 PRINTED NAME
DIRECTOR
 PRINTED TITLE


 SIGNATURE
CHRISTOPHER VICERE
 PRINTED NAME
VP-FINANCE
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 27 day of MARCH

Notarization:
 Subscribed and sworn to before me
 this 27 day of MARCH


 Signature of Notary
 Seal

 *Insert EXACT legal name of the applicant


 Signature of Notary
 Seal


SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

UNFINISHED OR SHELL SPACE: NOT GERMANE

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data are available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES: NOT APPLICABLE

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

I. Criterion 1110.1730 - General Long Term Care (Repealed)

1. Applicants proposing to establish, expand and/or modernize General Long Term Care must submit the following information:

Indicate bed capacity changes by Service:
action(s):

Indicate # of beds changed by

Category of Service	# Existing Beds	# Proposed Beds
<input type="checkbox"/> General Long Term Care		

2. READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X				
1110.1730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X			
1110.1730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X				
1110.1730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X			
1110.1730(b)(5) - Planning Area Need - Service Accessibility	X				
1110.1730(c)(1) - Description of Continuum of Care				X	
1110.1730(c)(2) - Components				X	
1110.1730(c)(3) - Documentation				X	
1110.1730(d)(1) - Description of Defined Population to be Served					X
1110.1730(d)(2) - Documentation of Need					X
1110.1730(d)(3) - Documentation Related to Cited Problems			X		
1110.1730(e)(1) - Unnecessary Duplication of Services	X				
1110.1730(e)(2) - Maldistribution	X				
1110.1730(e)(3) - Impact of Project on Other Area Providers	X				
1110.1730(f)(1) - Deteriorated Facilities			X		
1110.1730(f)(2) & (3) - Documentation			X		

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: Indicate the dollar amount to be provided from the following sources:

9,885,500	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
9,885,500	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT 28 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Not Germane as project is being funded through internal sources, i.e., cash.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERIC ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing – ALL CASH PROJECT NO DEBT, NOT GERMANE

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE											
Department (list below)	A	B	C		D	E		F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*		Gross Sq. Ft. Mod.	Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
Nursing	\$173.12	\$112.94	41,979			6,023			\$7,267,400	\$680,221	\$7,947,621
Contingency	\$16.69	\$19.93	41,979			6,023			\$700,656	\$120,039	\$820,695
TOTALS	\$189.81	\$132.87	41,979			6,023			\$7,968,056	\$800,260	\$8,768,316

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

XI. Safety Net Impact Statement – NOT GERMANE TO LONG TERM CARE

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:**

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	2011	2010	2009
Inpatient	19,587	21,200	17,327
Outpatient	0	0	0
Total	19,587	21,200	17,327

Medicaid (revenue)	2011	2010	2009
Inpatient	3,036,294	3,031,696	2,436,758
Outpatient	0	0	0
Total	3,036,294	3,031,696	2,436,758

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care Information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Applicant Identification

Corporations and limited liability companies must provide an Illinois certificate of good standing. Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

The Applicants to this project are **Wauconda Associates, LLC** (owner) and **Wauconda Healthcare and Rehabilitation Centre, LLC** (operator/Licensee). Each entity is a limited liability corporation and their respective Certificates of Good Standing from the Illinois Secretary of State's office are appended in **ATTACHMENT-1A**.

ATTACHMENT-1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUCONDA ASSOCIATES, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 01, 2000, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1212402408

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of MAY A.D. 2012 . . .

Jesse White

SECRETARY OF STATE

ATTACHMENT- 1A



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 01, 2000, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1212402424

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of MAY A.D. 2012 .

Jesse White

SECRETARY OF STATE

ATTACHMENT - 1A

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(CONTINUED II)**

Site Ownership

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

Wauconda Associates, LLC is the owner of the site. The Certificate of Good Standing is appended as **ATTACHMENT-2A**. Additional land is being purchased to accommodate this project, a copy of the property tax statement and the fully executed purchase and sales agreement is appended as **ATTACHMENT-2B**.

ATTACHMENT-2



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUCONDA ASSOCIATES, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 01, 2000, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1212402408

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 3RD
day of MAY A.D. 2012

Jesse White

SECRETARY OF STATE

ATTACHMENT - 2A



Lake County

FROM THE OFFICE OF: ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL. 60085-4361
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

1ST INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year 2010

09-35-200-009

09-35-200-009



WAUCONDA HEALTH CARE
176 THOMAS CT
WAUCONDA IL 60084-2451



Taxes Due on or before 6/6/2011

\$72,213.79 DUE

0935200009000000007221379201014

00183836

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓



Lake County

FROM THE OFFICE OF: ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL. 60085-4361
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

2ND INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year 2010

09-35-200-009

2



WAUCONDA HEALTH CARE
176 THOMAS CT
WAUCONDA IL 60084-2451

Taxes Due on or before 9/6/2011

\$72,213.79 DUE

0935200009000000007221379201023

09-35-200-009

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓

Property Location: 176 THOMAS CT
WAUCONDA
Legal Description: (EX N 30 FT) ALSO (EX S 826 FT) W 196.34FT E 726 F
T NW1/4 NE1/4

Pin Number 09-36-200-009
Tax Year 2010
Tax Code 13041
Acres 0.00

Taxing Body	Rate	Current Amount	Change From Prior Year	Land Value	
COUNTY OF LAKE	0.3980	\$7,040.07	626.22	+ Building Value	\$1,616,574
COUNTY OF LAKE PENSION	0.1070	\$1,892.68	263.22	x State Multiplier	1.0199
VIL OF WAUCONDA	0.7720	\$13,655.82	914.82	= Equalized Value	\$1,768,862
VIL OF WAUCONDA PENSION	0.1430	\$2,528.47	397.30	+ Farm Land and Bldg Value	
ROAD AND BRIDGE-WAUCONDA	0.0220	\$389.15	-96.22	+ State Assessed Pollution Ctr	
WAUCONDA FIRE PROT DIST	0.4160	\$7,358.47	7358.47	+ State Assessed Railroads	
WAUCONDA FIRE PROT DIST PENSION	0.0840	\$1,132.07	1132.07	= Total Assessed Value	\$1,768,862
WAUCONDA AREA PUBLIC LIBRARY DISTRICT	0.3400	\$6,014.13	536.37	- Fully Exempt	
WAUCONDA AREA PUBLIC LIBRARY DISTRICT PENSION	0.0280	\$512.87	62.27	- Senior Freeze	
WAUCONDA PARK DIST	0.2910	\$5,147.38	293.67	- Home Improvement	
WAUCONDA PARK DIST PENSION	0.0400	\$707.54	66.16	- General Homestead	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118	4.6080	\$81,509.17	11338.26	- Senior Homestead	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118 PENSION	0.1940	\$3,431.80	311.38	- Disabled / Veterans	
COLLEGE OF LAKE COUNTY #532	0.2180	\$3,856.12	389.18	- Returning Veterans	
SPECIAL ROAD IMPROVEMENT WAUCONDA GRAVEL	0.1400	\$2,476.41	378.91	= Taxable Valuation	\$1,768,862
FOREST PRESERVE	0.1800	\$3,360.84	15.24	x Tax Rate	8.1650
FOREST PRESERVE PENSION	0.0080	\$141.50	20.16	= Real Estate Tax	\$144,427.58
TOWNSHIP OF WAUCONDA	0.1600	\$2,830.16	247.31	+ Special Service Area	
TOWNSHIP OF WAUCONDA PENSION	0.0250	\$442.21	76.18	+ Drainage	
TOTALS	8.1650	\$144,427.58	\$24,332.75	= Total Current Year Tax	\$144,427.58
				+ Omitted Tax	
				+ Forfeited Tax	
				= TOTAL TAX BILLED	\$144,427.58
				Fair Market Value	\$5,306,586
				1st Installment Due 6/6/2011	\$72,213.79
				2nd Installment Due 9/6/2011	\$72,213.79

ATTACHMENT - 2B



Lake County

FROM THE OFFICE OF: ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL. 60085-1367
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

1ST INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year: 2010

09-35-200-059

09-35-200-059



WAUCONDA HEALTH CARE
176 THOMAS CT
WAUCONDA IL 60084-2451



Taxes Due on or before 6/6/2011
\$4,025.46 DUE

093520005900000000402546201015

00163838

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓



Lake County

FROM THE OFFICE OF: ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL. 60085-1367
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

2ND INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year: 2010

09-35-200-059

2



WAUCONDA HEALTH CARE
176 THOMAS CT
WAUCONDA IL 60084-2451

Taxes Due on or before 9/6/2011
\$4,025.47 DUE

093520005900000000402547201027

09-35-200-059

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓

Property Location: 176 THOMAS CT
WAUCONDA

Legal Description: PT NW NE; E150' W594' (EX S770' & EX BEG CLN THOMA
S CT 64' NLY OF NLN S770', N75', ELY 137.33', S66'

Pin Number
09-35-200-059

Tax Year
2010

Tax Code
13041

Acres
1.56

Taxing Body	Rate	Current Amount	Change From Prior Year	Land Value	
COUNTY OF LAKE	0.3980	\$392.46	34.75	\$93,604	
COUNTY OF LAKE PENSION	0.1070	\$105.50	14.63	+ Building Value	\$3,075
VIL OF WAUCONDA	0.7720	\$761.21	30.82	x State Multiplier	1.0199
VIL OF WAUCONDA PENSION	0.1430	\$141.00	22.08	= Equalized Value	\$98,603
ROAD AND BRIDGE-WAUCONDA	0.0220	\$21.69	-5.38	+ Farm Land and Bldg Value	
WAUCONDA FIRE PROT DIST	0.4180	\$410.19	410.19	+ State Assessed Pollution Ctrl	
WAUCONDA FIRE PROT DIST PENSION	0.0540	\$53.11	63.11	+ State Assessed Railroads	
WAUCONDA AREA PUBLIC LIBRARY DISTRICT	0.3400	\$335.25	29.74	= Total Assessed Value	\$98,603
WAUCONDA AREA PUBLIC LIBRARY DISTRICT PENSION	0.0290	\$28.59	3.45	- Fully Exempt	
WAUCONDA PARK DIST	0.2910	\$286.94	16.24	- Senior Freeze	
WAUCONDA PARK DIST PENSION	0.0400	\$39.44	3.57	- Home Improvement	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118	4.6080	\$4,543.64	630.06	- General Homestead	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118 PENSION	0.1940	\$191.28	17.26	- Senior Homestead	
COLLEGE OF LAKE COUNTY #532	0.2160	\$214.85	21.60	- Disabled / Veterans	
SPECIAL ROAD IMPROVEMENT WAUCONDA GRAVEL	0.1400	\$138.04	21.06	- Returning Veterans	
FOREST PRESERVE	0.1900	\$187.35	0.75	= Taxable Valuation	\$98,603
FOREST PRESERVE PENSION	0.0080	\$7.88	1.11	x Tax Rate	8.1650
TOWNSHIP OF WAUCONDA	0.1600	\$157.76	13.71	= Real Estate Tax	\$8,050.93
TOWNSHIP OF WAUCONDA PENSION	0.0250	\$24.85	4.35	+ Special Service Area	
				+ Drainage	
				= Total Current Year Tax	\$8,050.93
				+ Omitted Tax	
				+ Forfeited Tax	
				= TOTAL TAX BILLED	\$8,050.93
				Fair Market Value	\$295,809
				1st Installment Due 6/6/2011	\$4,025.46
				2nd Installment Due 9/6/2011	\$4,025.47
TOTALS	8.1650	\$8,050.93	\$1,353.01		

ATTACHMENT - 2B



Lake County

FROM THE OFFICE OF ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL 60085-4361
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

1ST INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year 2010

09-35-200-057

09-35-200-057



TRUST 118167
176 THOMAS CT
WAUCONDA IL 60084-2451



Taxes Due on or before 6/6/2011

\$124.92 DUE

093520005700000000012492201012

00183837

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓



Lake County

FROM THE OFFICE OF ROBERT SKIDMORE, LAKE COUNTY COLLECTOR

Make Checks Payable to: LAKE COUNTY COLLECTOR
Please Remit to: 18 N. COUNTY ST., SUITE 102, WAUKEGAN, IL 60085-4361
Avoid duplicate payments. Ask your lender if it pays your bill,
especially if you have refinanced.

2ND INSTALLMENT
PAYMENT COUPON
RETURN WITH PAYMENT

Tax Year 2010

09-35-200-057

2

09-35-200-057



TRUST 118167
176 THOMAS CT
WAUCONDA IL 60084-2451

Taxes Due on or before 9/6/2011

\$124.93 DUE

093520005700000000012493201023

YOUR CANCELLED CHECK IS YOUR RECEIPT

↓ TEAR HERE ↓

Property Location: 0 OAKS AVE
WAUCONDA
Legal Description: PT NW1/4 NE1/4; PT LYG BTWN W894' & E726' (EX N30' & EX S 826')

Pin Number 09-35-200-057
Tax Year 2010
Tax Code 13041
Acres 0.05

Taxing Body	Rate	Current Amount	Change From Prior Year	Land Value	
COUNTY OF LAKE	0.3960	\$12.19	1.09	+ Building Value	\$3,000
COUNTY OF LAKE PENSION	0.1070	\$3.28	0.45	x State Multiplier	1.0199
VIL OF WAUCONDA	0.7720	\$23.62	1.57	= Equalized Value	\$3,060
VIL OF WAUCONDA PENSION	0.1430	\$4.38	0.69	+ Farm Land and Bldg Value	
ROAD AND BRIDGE-WAUCONDA	0.0220	\$0.67	-0.17	+ State Assessed Pollution Ctrl	
WAUCONDA FIRE PROT DIST	0.4160	\$12.73	12.73	+ State Assessed Railroads	
WAUCONDA FIRE PROT DIST PENSION	0.0640	\$1.96	1.96	= Total Assessed Value	\$3,060
WAUCONDA AREA PUBLIC LIBRARY DISTRICT	0.3400	\$10.41	0.03	- Fully Exempt	
WAUCONDA AREA PUBLIC LIBRARY DISTRICT PENSION	0.0290	\$0.89	0.11	- Senior Freeze	
WAUCONDA PARK DIST	0.2910	\$8.89	0.49	- Home Improvement	
WAUCONDA PARK DIST PENSION	0.0400	\$1.22	0.11	- General Homestead	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118	4.6000	\$141.00	19.56	- Senior Homestead	
WAUCONDA COMM UNIT SCHOOL DISTRICT #118 PENSION	0.1940	\$5.94	0.54	- Disabled / Veterans	
COLLEGE OF LAKE COUNTY #532	0.2180	\$6.67	0.67	- Returning Veterans	
SPECIAL ROAD IMPROVEMENT WAUCONDA GRAVEL	0.1400	\$4.28	0.65	= Taxable Valuation	\$3,060
FOREST PRESERVE	0.1900	\$5.82	0.03	x Tax Rate	8.1650
FOREST PRESERVE PENSION	0.0080	\$0.24	0.03	= Real Estate Tax	\$249.85
TOWNSHIP OF WAUCONDA	0.1600	\$4.88	0.42	+ Special Service Area	
TOWNSHIP OF WAUCONDA PENSION	0.0250	\$0.77	0.14	+ Drainage	
TOTALS	8.1650	\$249.85	\$42.01	= Total Current Year Tax	\$249.85
				+ Omitted Tax	
				+ Forfeited Tax	
				= TOTAL TAX BILLED	\$249.85
				Fair Market Value	\$9,180
				1st Installment Due 6/6/2011	\$124.92
				2nd Installment Due 9/6/2011	\$124.93

ATTACHMENT - 2 B



CHICAGO TITLE AND TRUST COMPANY

171 NORTH CLARK, CHICAGO, ILLINOIS 60601

Escrow Trustee:
Escrow Administrator: REGINA E. SPRINGER
Phone no.: (312)223-5448
Fax no.: (312)223-2108

STRICT JOINT ORDER #1 ESCROW TRUST INSTRUCTIONS (EARNEST MONEY)

ESCROW TRUST NO.: D2 201210859 DATE: 03/06/12

To: Chicago Title and Trust Company, Escrow Trustee:

Customer Identification:

Seller: BOEHMER AUTOMOTIVE INC.

Purchaser: WAUCONDA ASSOCIATES, L.L.C.

Property Address: 416 WEST LIBERTY STREET, WAUCONDA, ILLINOIS 60084

Property located to the South of [signature]

Project Reference:

Proposed Disbursement Date: [signature] 2012

Deposits:

1. The sum of \$ 25000.00 by ~~CASHIERS OR CERTIFIED CHECK~~ representing EARNEST MONEY

Delivery of Deposits:

The above-referenced escrow trust deposits ("deposits") are deposited with the escrow trustee to be delivered by it only upon the receipt of a joint order of the undersigned or their respective or assigns.

In no case shall the above-mentioned deposits be surrendered except upon the receipt of an order signed by the parties hereto, their respective legal representatives or assigns, or in obedience to the court order described below.

Billing Instructions:

Escrow trust fee will be billed as follows:
1/2 TO EACH PARTY

The parties acknowledge that beginning after a period of one year from the date of this agreement, Chicago Title and Trust Company will impose an administrative maintenance fee (quarterly, semi-annually, or annually) equivalent to the fee set forth on the Company's then current rate schedule.

This fee may be deducted from the outstanding escrow balance or billed to 1/2 TO EACH PARTY

PLEASE NOTE: The escrow trust fee for these joint order escrow trust instructions is due and payable within 30 days from the projected disbursement date (which may be amended by joint written direction of the parties hereto). In the event no projected disbursement date is ascertainable, said escrow trust fee is to be billed at acceptance and is due and payable within 30 days from the billing date. Chicago Title and Trust Company, at its sole discretion, may reduce or waive the escrow trust fee for these joint order escrow instructions in the event the funds on deposit herein are transferred to or disbursed in connection with said escrow trust instructions or any closing transaction established at Chicago Title.

Escrow Trust No.: 02 201210859

Investment:

Deposits made pursuant to these instructions may be invested on behalf of any party or parties hereto; provided that any direction to escrow trustee for such investment shall be expressed in writing and contain the consent of all parties to this escrow, and also provided that escrow trustee is in receipt of the taxpayer's identification number and investment forms as required. Escrow trustee will, upon request, furnish information concerning its procedures and fee schedule for investment.

In the event the escrow trustee is requested to invest deposits hereunder, Chicago Title and Trust Company is not to be held responsible for any loss of principal or interest which may be incurred as a result of making the investments or redeeming said investment for the purposes of these escrow trust instructions.

Direction Not to Invest/Right to Commingle:

Except as to deposits of funds for which escrow trustee has received express written direction concerning investment or other handling, the parties hereto direct the escrow trustee NOT to invest any funds deposited by the parties under the terms of this escrow and waive any rights which they may have under Section 2-8 of the Corporate Fiduciary Act (205 ILCS 620/2-8) to receive interest on funds deposited hereunder. In the absence of an authorized direction to invest funds, the parties hereto agree that the escrow trustee shall be under no duty to invest or reinvest any such funds at any time held by it hereunder; and, further, that escrow trustee may commingle such funds with other deposits or with its own funds in the manner provided for the administration of funds under said Section 2-8 and may use any part or all of such funds for its own benefit without obligation to any party for interest or earnings derived thereby, if any. Provided, however, nothing herein shall diminish escrow trustee's obligation to apply the full amount of such funds in accordance with the terms of these escrow instructions.

Compliance With Court Order:

The undersigned authorize and direct the escrow trustee to disregard any and all notices, warnings or demands given or made by the undersigned (other than jointly) or by any other person. The said undersigned also hereby authorize and direct the escrow trustee to accept, comply with, and obey any and all writs, orders, judgments or decrees entered or issued by any court with or without jurisdiction; and in case the said escrow trustee obeys or complies with any such writ, order, judgment or decree of any court, it shall not be liable to any of the parties hereto or any other person, by reason of such compliance, notwithstanding any such writ, order, judgment or decree be entered without jurisdiction or be subsequently reversed, modified, annulled, set aside or vacated. In case the escrow trustee is made a party defendant to any suit or proceedings regarding this escrow trust, the undersigned, for themselves, their heirs, personal representatives, successors, and assigns, jointly and severally, agree to pay to said escrow trustee, upon written demand, all costs, attorney's fees, and expenses incurred with respect thereto. The escrow trustee shall have a lien on the deposit(s) herein for any and all such costs, fees and expenses. If said costs, fees and expenses are not paid, then the escrow trustee shall have the right to reimburse itself out of the said deposit(s).

Execution:

These escrow trust instructions are governed by and are to be construed under the laws of the state of Illinois. The escrow trust instructions, amendments or supplemental instructions hereto, may be executed in counterparts, each of which shall be deemed an original and all such counterparts together shall constitute one and the same instrument.

For Seller:

Name: RICHARD J. NAKON & ASSOC.,

By: RICHARD J. NAKON

Address: 121 EAST LIBERTY STREET
WAUCONDA, ILLINOIS 60084

Phone: (847) 528-0826

Fax: (847) 528-7466

Signature: _____

Accepted For Chicago Title and Trust Company, as Escrow Trustee.

By: _____

Escrow Admin: REGINA SPRINGER

STANDARD FORM NO. 100

For Purchaser:

Name: KOREY, CUTTER, HEATHER & RICHARDSON, LL

By: CARTER A. KOREY

Address: 20 SOUTH CLARK
SUITE 600
CHICAGO, ILLINOIS 60603

Phone: (312) 372-7075

Fax: (312) 372-7076

Signature: _____

Date: 3/9/2012

20110725

21135

LANCASTER - SPECIAL PAYROLL
9051 N. PULASKI ROAD
CHICAGO, IL 60630



7 77710

3/7/2012

PAY TO THE ORDER OF Chicago Title and Trust Company

\$ 25,000.00

Twenty-Five Thousand and 00/100

DOLLARS

Chicago Title and Trust Company

Christy P. Vercare

MEMO

⑈02⑈⑈35⑈ ⑆07⑈⑈0000⑈⑈3⑈⑈ 5330054⑈⑈76⑈

LANCASTER - SPECIAL PAYROLL
Chicago Title and Trust Company
Due Wauconda Associates

2.16 Acres Land Account

3/7/2012

21135
25,000.00

J.P.Morgan - Special

25,000.00

RECEIVED BY: Chicago Title
PRINT NAME: Regina Springer
DATE: 3/9/2012

ATTACHMENT - 2B

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT ("Agreement"), is made and entered into this 2nd day of March, 2012 (the "Effective Date"), by and between BOEHMER AUTOMOTIVE INC., an Illinois corporation f/k/a Boehmer Chevrolet Sales, Inc. ("Seller"), and WAUCONDA ASSOCIATES, L.L.C., an Illinois limited liability company, or its nominee ("Purchaser").

RECITALS:

WHEREAS, Seller is the owner of record of the real property located to the South of the property commonly known as 416 West Liberty Street, Wauconda, Illinois 60084, legally described on Exhibit A attached hereto (the "Property");

WHEREAS, Seller now desires to sell to Purchaser and Purchaser now desires to buy from Seller the Property, together with all rights, easements and appurtenances pertaining thereto, and all improvements, trees, bushes, landscaping and foliage located thereon;

NOW THEREFORE, in consideration of the recitals which are hereby specifically by reference incorporated herein and in further consideration of the mutual promises of the parties, it is hereby covenanted and agreed as follows:

1. Feasibility Period.

Purchaser shall have until ninety (90) days after the Effective Date hereof (the "Feasibility Period") to:

- a. Investigate the physical condition of the Property.
- b. Investigate such other matters as may be deemed necessary or appropriate by Purchaser.

From and after the date hereof, Purchaser and its employees, agents or independent contractors shall be permitted to come onto the Property to complete any physical investigations necessary for the performance of this Agreement. Purchaser agrees to indemnify and hold Seller harmless from and against any mechanic's lien or other claim for the providing of material or services upon the Property in connection therewith and any other claims, causes of action or expenses arising out of any act, occurrence or omission of its employees, agents or independent contractors while on the Property.

Purchaser shall immediately restore the Property to its condition prior to any such testing after the testing has been completed.

Prior to the expiration of the Feasibility Period, Purchaser shall give written notice to Seller whether or not Purchaser is satisfied with the matters described in this paragraph 1.

If such notice is in the negative, this Agreement shall be deemed to be terminated, in which event the Earnest Money shall be returned to Purchaser, and Purchaser, as a condition to the return of the Earnest Money, shall deliver to Seller all plats, plans, soil tests, engineering and studies prepared by and for Purchaser with respect to the Property.

2. Preliminary Deliveries.

Within thirty (30) days after the Effective Date hereof, Seller shall deliver the following to Purchaser:

- a. A current commitment for title insurance issued on or after the Effective Date by Chicago Title Insurance Company (which may be in nominal amount) showing title to the Property to be in Seller, subject only to:
 - i. the general and usual exceptions contained in such policies as are issued by Chicago Title Insurance Company; and
 - ii. those special exceptions approved by Purchaser after receipt of the commitment for title insurance ("Permitted Exceptions").

Purchaser shall order, obtain and pay for:

- b. A survey prepared in accordance with the Standards for Land Title Surveys of American Land Title Association and American Congress on Surveying and Mapping promulgated in 1999 ("ALTA Survey"), currently certified by a registered Illinois land surveyor sufficient to enable the title insurance company to give coverage over matters of survey, showing the exact boundaries, legal description and acreage contained within the Property, designating all improvements, showing no fencing or other improvements of every kind which might constitute encroachments in either direction over the boundaries, all public or private utility or drainage easements or easements of passage of record, and designating all flood plain floodways and wetlands disclosed by the public records.

If the ALTA Survey set forth in 2b above shall disclose defects, encumbrances or exceptions to title or survey not permitted by this Agreement, Seller shall have thirty (30) days from the date of notice thereof to remove same. If Seller fails to have the defects, encumbrances or exceptions to survey not permitted by this Agreement removed within said thirty (30) day period, Purchaser may either terminate this Agreement or, upon notice to Seller within ten (10) days after the expiration of the thirty (30) day period, accept the survey as then it is with the right to deduct from the portion of the Purchaser Price then due liens or encumbrances of a definite or

ascertainable amount not exceeding Fifty Thousand Dollars (\$50,000.00). In the event that Purchaser shall fail to elect either remedy within said ten (10) day period, then this Agreement shall thereupon terminate and the Earnest Money shall forthwith be refunded to Purchaser.

Within five (5) days from the Effective Date, Seller shall deliver the following to Purchaser:

- c. all plats, plans, studies, soil tests, surveys, engineering reports, real estate tax bills or notices, proposed assessed valuation or similar data in the possession of Seller relating to the physical condition or the proposed use or development of the Property. Seller shall provide all of such documents to Purchaser together with a list of such documents describing each of such documents so provided in detail.

3. Property.

Purchaser agrees to purchase from Seller and Seller agrees to sell to Purchaser the Property legally described in Exhibit A and to cause to be granted to Purchaser or its nominee good and merchantable title thereto by special warranty deed with appropriate revenue stamps affixed, subject only to the Permitted Exceptions.

4. Purchase Price; Closing; Earnest Money.

- a. **Purchase Price.** Subject to adjustments and prorations which shall be paid in immediately-available funds at the time of Closing described below, the purchase price (the "Purchase Price") shall be Four Hundred Fifty-Eight Thousand Six Hundred Eighty-Six Dollars and 80/100 (\$458,686.80) or \$4.875 per square foot for the 94,089.60 square feet of the Property. In the event the survey discloses that the property is more or less than 94,089.60 square feet, the purchase price shall be recalculated at \$4.875 per surveyed square foot.

Subject to recalculation, if any, as stated above, Purchaser shall pay the Purchase Price as follows: i) \$58,686.80 to be paid at Closing of which \$25,000.00 shall come from the turning over of the Earnest Money and the remaining \$33,686.80 by cashier's or certified check or wire transfer; ii) an annual payment of \$100,000.00 due each consecutive yearly anniversary of the Closing Date for four (4) consecutive years; and iii) interest accruing from the Closing Date at 0.75% per annum, to be paid annually in addition to and with the payments made in section 4(a)(ii) above, coming to a total of \$7,500.00.

In order to ensure the above stated payments, Purchaser shall deposit with Chicago Title on or prior to the Closing Date, the original executed Promissory Note with the personal guarantees of Christopher Vicere and Laura Zung, a copy of which is attached hereto as Exhibit B.

- b. **Closing.** The Closing shall take place on June 5, 2012, unless an earlier date is mutually agreed to by Seller and Purchaser (the "Closing Date"). The closing of the transaction contemplated herein shall take place at the office of Chicago Title Insurance Company nearest to the Property, using a New York style closing whereby Title Insurer insures over the intervening gap between the title insurance commitment date and the recordation date of the Stamped Warranty Deed. The cost of the New York style closing is to be borne equally by Seller and Purchaser.
- c. **Earnest Money.** Within five (5) days of acceptance of the Agreement by Seller, Purchaser shall deposit with Chicago Title Insurance Company (the "Escrow Agent") earnest money in an amount equal Twenty-Five Thousand Dollars (\$25,000.00) (the "Earnest Money"). The term "Earnest Money" shall include the initial Earnest Money and the interest earned thereon, if any. The Earnest Money shall be held under strict joint order escrow instructions in an interest bearing money market account (Purchaser shall decide whether it wants the Earnest Money placed in an interest bearing money market account and will be solely responsible for the cost and expense of the same). The parties agree to promptly direct the Escrow Agent to return the Earnest Money to Purchaser or deliver it to Seller in accordance with the terms hereof. The money market account, if any, shall bear the tax identification number of Purchaser and the interest earned thereon, if any, shall be paid to Purchaser at Closing.

5. **Escrow; Trust; Conveyance.**

On or before the Closing Date, the parties shall enter into a deed and purchase money escrow with Chicago Title. Said deed and purchase money escrow shall contain, in addition to the standard provisions contained in said instrument, clauses incorporating the following:

- a. Chicago Title shall within thirty (30) days after the date hereof issue a commitment for title insurance, Form B, covering the Property in the amount of the Purchase Price, and, at Closing an owner's title insurance policy in the amount of the Purchase Price. Seller shall also cause Chicago Title at Closing to issue an extended coverage endorsement insuring over and against unrecorded mechanic's liens, rights of parties in possession, questions of survey, unrecorded easements, and taxes and special assessments not shown of record, an access endorsement insuring vehicular access and a 3.0 zoning endorsement demonstrating that the Property is zoned for Purchaser's contemplated use (to build and operate a skilled nursing facility). Said commitment shall show good title in Seller, subject only to Permitted Exceptions; provided, that Seller shall cause any title exception relating to any mortgage lien to be removed on or before the date of Closing. If any title commitment shall disclose defects, encumbrances, or exceptions to title not permitted by this Agreement, Seller shall have thirty (30) days from the date of notice thereof to remove same. If Seller fails to have the defects, encumbrances, or exceptions to title not permitted by this

Agreement removed within said thirty (30) day period, Purchaser may either terminate this Agreement or, upon notice to Seller within ten (10) days after the expiration of the thirty (30) day period, take title as it then is, with the right to deduct from the portion of the Purchase Price then due, liens or encumbrances of a definite or ascertainable amount. In the event that Purchaser shall fail to elect either remedy within said ten (10) day period, then this Agreement shall thereupon terminate and the Earnest Money shall forthwith be refunded to Purchaser. The expense of said title commitment shall be paid by Seller and the expense of extended coverage endorsement, access endorsement and zoning endorsement shall be paid by Purchaser. In addition, all other title endorsements required by Purchaser shall be obtained by and paid for by Purchaser. Seller shall furnish Chicago Title with all documents, affidavits and undertakings which may be necessary in order to cause good title to be conveyed to Purchaser or its nominee in compliance with this Agreement and in order to cause Chicago Title to issue its title commitment or owner's guaranty policy.

- b.
 - i. Seller shall deposit with Chicago Title the following documents on or prior to the Closing Date:
 - (1) Special Warranty Deed conveying the Property to Purchaser;
 - (2) Transfer declarations, including State of Illinois, County of Lake and Village of Wauconda, if applicable;
 - (3) ALTA Statement;
 - (4) FIRPTA Affidavit;
 - (5) GAP Undertaking Statement;
 - (6) Substitute Form 1099 exemption;
 - (7) Such other documents or instruments required by Chicago Title to complete this transaction.
 - ii. Purchaser shall deposit with Chicago Title the following documents on or prior to Closing Date:
 - (1) the sum described in paragraph 4(a)(i) above, less Earnest Money, by cashier's or certified check or wire transfer plus or minus applicable prorations;

- (2) original executed Promissory Note with the personal guaranties of Christopher Vicere and Laura Zung, a copy of which is attached hereto as Exhibit B.
 - (3) ALTA Statement executed by Purchaser;
 - (4) Certified copy of Purchaser's Board of Directors and/or Members Resolution authorizing this Agreement;
 - (5) GAP Undertaking Statement, if necessary; and
 - (6) Such other documents or instruments required by Chicago Title to complete this transaction.
- iii. The parties shall jointly deposit with Chicago Title executed closing statements and a joint direction therein directing Chicago Title to deliver the Earnest Money to the Deed and Money Escrow.
- c. Chicago Title shall be empowered and directed by Seller to perform the conditions of this Agreement to be performed by Seller in such manner that, when the commitment for title insurance shall have been prepared and the deposits described in Paragraphs 5b(i), 5b(ii) and 5b(iii) above shall have been made, then Chicago Title shall cause the Property to be conveyed to Purchaser or its nominee and the Purchase Price deposited pursuant to Paragraph 4.a. and other funds payable hereunder to be paid Seller, whereupon Closing shall be deemed to have occurred.

6. Disbursements.

Upon execution, delivery and recording of the Special Warranty Deed for the Property, Seller shall instruct Chicago Title that when it is prepared to issue its Owners Title Insurance Policy in the amount of the Purchase Price then due hereunder, subject to Permitted Exceptions, it shall disburse the funds held by it as follows:

- a. Pay State and County revenue stamps attached to the deed, the cost of the owners title insurance policy (Purchaser shall pay for all requested title endorsements), and one-half of the escrow fees including the New York style closing fee.
- b. Bill Purchaser for municipal revenue stamps attached to deed, if any, recording deed to Purchaser, for all requested title endorsements, and one-half of the escrow fees including the New York style closing fee.
- c. Pay the balance to Seller.

7. **Seller's Assurances.**

- a. **Seller's Representations and Warranties.** Seller warrants, represents and covenants the following matters to Purchaser, each of which is warranted to be true and correct as of the date hereof and as of the Closing:
- i. Until the date of conveyance of the Property to Purchaser, Seller shall at its sole cost maintain same in the condition in which it presently exists, free from waste and neglect, and shall utilize same only for the purposes for which it is presently used.
 - ii. Seller now has good and marketable title to the Property subject only to the Permitted Exceptions and to such existing mortgages and other encumbrances, if any, as shall be canceled or released at Closing.
 - iii. Seller has no knowledge of any pending or threatened matters of litigation, administrative action or examination, claim or demand whatsoever relating to the Property.
 - iv. Seller has no knowledge of any pending or any threatened eminent domain, condemnation or other government taking of the Property or any part thereof.
 - v. Seller has no knowledge of any special understandings or agreements between Seller and the Village of Wauconda (or any other governmental authority) providing for, limiting or defining the requirement of Purchaser to have to:
 - (1) share in the cost of public improvements by recapture, contribution, special assessment or otherwise; or
 - (2) install any public improvements; or
 - (3) contribute in land or in cash to any school, library, park or other sort of county, municipal or governmental district or body.
 - vi. There are no parties in possession of the Property, nor are there any parties with possessory rights in the Property other than Seller.
 - vii. All action required of Seller by this Agreement to effectuate the transaction contemplated hereby have been or will be promptly taken in good faith by Seller and its representatives and agents.
 - viii. Seller has received no written notice and Seller has no actual knowledge, without the requirement of investigation, of any violation of any

Environmental Laws regarding the Property. As used herein, "Environmental Laws" shall mean all federal, state and local environmental health and safety statutes, ordinances, codes, rules, regulations, orders and decrees regulating, relating to or imposing liability or standards concerning or in connection with hazardous materials, as such term is defined in any of such statutes.

ix. **Environmental Matters:**

The term "Hazardous Materials" shall mean any substance, material, waste, gas or particulate matter which is regulated by any local governmental authority, the State of Illinois or the United States Government, including, but not limited to, (1) any material or substance which is defined as a "hazardous waste", or "restricted hazardous waste" under any provision of Illinois law; (2) petroleum; (3) asbestos; (4) any polychlorinated biphenyl; (5) any radioactive material; (6) any material designated as a "hazardous substance" pursuant to Section 311 of the Federal Water Pollution Control Act (the Clean Water Act), 33 U.S.C. '1251 et seq. (33 U.S.C. '1321); and (7) any material defined as a "hazardous waste" pursuant to Section 1004 of the Resource Conservation and Recovery Act, 42 U.S.C. '6901 et seq. (42 U.S.C. '6903), or (8) defined as a "hazardous substance" pursuant to Section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. '9601 et seq. (42 U.S.C. '9601). The term "Environmental Laws" shall mean all statutes specifically described in the foregoing sentence and all federal, state and local environmental health and safety statutes, ordinances, codes, rules, regulations, orders and decrees regulating, relating to or imposing liability or standards concerning or in connection with Hazardous Materials.

Seller represents and warrants that (1) to the best of Sellers knowledge, the Property is in compliance with all Environmental Laws; (2) no notice, demand, claim or other communication has been given to or served on Seller and Seller has no knowledge of any such notice given to previous owners or tenants of the Property, from any entity, governmental body or individual claiming any violation of any Environmental Laws or demanding payment, contribution, indemnification, remedial action, removal action or any other action or inaction with respect to any actual or alleged environmental damage or injury to persons, property or natural resources (any of the foregoing, whether now existing or hereafter brought, is herein called a "Claim"), and no basis for any Claim exists; (3) no underground storage tanks are located on the Property; (4) to the best of Sellers knowledge, the soil, surface water and ground water of, under or on the Property are free from any Hazardous Materials; (5) to the best of Sellers knowledge, the Property has never been used for or in connection with, and the Seller shall not permit or acquiesce in the use for or in connection with, the manufacture, refinement, treatment,

storage, generation, transport or hauling of any Hazardous Materials or the disposal of any such Hazardous Materials; (6) no Hazardous Materials have been discharged, dispersed, released, disposed of, or allowed to escape on, under or in the Property; and (7) to the best of Seller's knowledge, no asbestos or asbestos-containing materials have been installed, used, incorporated into or disposed of on the Property.

- x. Seller represents and warrants that it has received no notice that the Property or any part thereof is, and, to the best of its knowledge and belief, no part of the Property is located within any area that has been designated by the Federal Emergency Management Agency, or any other governmental body as located in a flood plain area.

8. Default.

- a. It is hereby stipulated and agreed that time is of the essence of this Agreement and each and every part thereof.
- b. If Purchaser shall fail to perform as provided herein, this Agreement shall be terminated and canceled if such failure is not cured within ten (10) days after delivery of written notice to Purchaser from Seller. The failure of Purchaser to cure any default on or prior to the expiration of such notice period shall constitute a default hereunder and entitle Seller to receive and retain all Earnest Money deposited with Chicago Title. Retention of the Earnest Money shall be Seller's sole remedy hereunder.
- c. If Seller shall fail to perform any covenant, term or condition of this Agreement or shall breach any warranty herein contained, and Seller shall fail to cure same within ten (10) days after delivery of written notice to Seller from Purchaser, then Purchaser may commence a specific performance action against Seller or demand termination of the Agreement and return of the Earnest Money. Provided, however, Purchaser shall have no right to recover any damages against Seller.

9. Real Estate Taxes; Possession.

- a. General real estate taxes for the Property shall be prorated to the date of Closing on the basis of the most recent ascertainable tax bill, and shall be prorated upon issuance of real estate tax bills for 2011 and 2012, and in the absence of a tax bill corresponding to the Property, the taxes shall be estimated on such other basis as shall be fair and equitable.
- b. Possession of the Property shall be delivered to Purchaser on the Closing Date.

10. Condemnation.

In the event that, prior to the date of Closing, all or any portion of the Property not yet conveyed to Purchaser, or any rights or easements therein shall be taken by condemnation or right of eminent domain or like process, or shall be threatened therewith, and the taking would have a materially adverse impact upon its proposed development of the Property, Purchaser shall, within thirty (30) days after having received notice thereof from Seller, elect in writing to either:

- a. Continue this Agreement in full force and effect, notwithstanding such taking or threatened taking. In such event, Seller shall deliver to Purchaser the summons and complaint initiating any condemnation proceedings forthwith after service thereof. Purchaser shall be entitled to appear and defend against same, and the total amount of any condemnation award made prior to Closing shall be paid to Seller and applied as a credit to Purchaser at the Closing, or in the event that the total amount of any condemnation award is paid after Closing, at Closing Seller will assign the right to receive such award to Purchaser; or
- b. Terminate this Agreement. In the event of any such termination, the Earnest Money shall be returned to Purchaser.
- c. Failure of Purchaser to make a written election as aforesaid shall constitute an election to continue this Agreement.

11. Broker's Commission.

Each of the parties represents and warrants to the other that it has not incurred and will not incur any other liability for finder's or brokerage fees or commissions in connection with this Agreement. It is agreed that if any claims for finder's or brokerage fees or commissions are ever made against Seller or Purchaser in connection with this transaction, all such claims shall be handled and paid by the party (the "Committing Party") whose actions or alleged commitments form the basis of such claim. The Committing Party further agrees to indemnify and hold the other harmless from and against any and all claims or demands with respect to any finder's or brokerage fees or commissions or other compensation asserted by any person, firm or corporation in connection with this Agreement or the transaction contemplated hereby. This representation shall survive Closing indefinitely.

12. Notices.

All notices required or desired to be furnished pursuant to or with respect to this Agreement shall be in writing and shall be personally served or sent by registered or certified mail, return receipt requested, postage prepaid, or by confirmed telecopy or facsimile transmission, to the respective parties at the following addresses:

IF TO SELLER: Boehmer Automotive Inc.
c/o Steven K. Boehmer
416 W. Liberty St.
Wauconda, IL 60084
Fax: _____

with copy to: Richard J. Nakon, Esq.
Richard J. Nakon & Associates
121 E. Liberty St.
Wauconda, IL 60084
Fax: 847/526-7456

IF TO PURCHASER: Wauconda Associates, L.L.C.
c/o Christopher Vicere
5061 N. Pulaski
Chicago, IL 60630
Fax: 773/478-1192

with copy to: Carter A. Korey, Esq.
Korey Cotter Heather & Richardson, LLC
20 S. Clark Street, Suite 500
Chicago, IL 60603
Fax: 312/372-7076

Any party may change its address, telephone number or facsimile number for purposes of service by delivery of written notice to all other parties designated above. Any notice mailed in the manner herein specified shall be deemed received on the second business day after mailing.

13. **Assignment.**

This Agreement may not be sold, transferred or assigned by Purchaser at any time to any person or party without the written consent of Seller, which consent shall not be reasonably withheld, delayed or objected to by Seller.

14. **Conditions Precedent to Closing.**

- a. In addition to any conditions provided in other provisions of this Agreement, Purchaser's obligation to purchase the Property is and shall be conditioned on the following:
 - i. The parties causing, prior to the Closing Date, the Property zoning classification to be changed so that Purchaser can build and operate a skilled nursing facility on the Property. If this is not achieved prior to the Closing

Date, Purchaser can elect to have this Agreement declared null and void with immediate return of the Earnest Money.

The cost for obtaining any change in zoning classification shall be at the sole cost and expense of the Purchaser.

- ii. The due performance by Seller of each and every covenant, undertaking and agreement to be performed by it hereunder and the truth of each representation and warranty made in this Agreement by Seller at the time at which the same is made and as of the Closing as if made on and as of the Closing.
- iii. Possession of the Property shall be delivered to Purchaser on the Closing Date free and clear of all tenancies and uses by Seller and any other party or parties.

15. Miscellaneous.

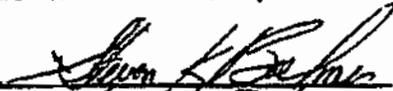
- a. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives, successors and assigns.
- b. This Agreement shall not be merged into any escrow agreement.
- c. This Agreement may be executed in counterparts, and all so executed shall constitute one and the same Agreement.
- d. This Agreement embodies the entire agreement between the parties with respect to the Property. No extension or amendment of this Agreement shall be made or claimed by any party or have any force or effect whatsoever unless same shall be set forth in writing and signed by the parties.
- e. Wherever applicable, the gender of any words used in this Agreement shall be construed to include any other gender, and any words used in the singular form shall be construed as though they were used in the plural form.
- f. Any party shall have the right, at its option, to waive any covenant, warranty, term or condition of this Agreement which the other party is obligated to perform or fulfill; provided, that any such waiver shall be in writing and delivered to the other party.
- g. This Agreement shall be govern by and construed in accordance with the statutes and laws of the State of Illinois. If any provision, clause or part of this Agreement, or the application thereof under certain circumstances, is held invalid, the remainder of this Agreement, or the application of such provision, clause or part under certain circumstances, shall not be affected thereby.

- h. In the event of litigation between the parties, the prevailing party shall be entitled to an award of its reasonable attorneys' fees and court costs incurred in any such proceeding.
- i. The parties intend to sign and deliver this Agreement by facsimile transmission. Each party agrees that the delivery of the Agreement by facsimile shall have the same force and effect as delivery of original signatures and that each party may use such facsimile signatures as evidence of the execution and delivery of the Agreement by all parties to the same extent that an original signature could be used.
- j. Whenever a date for performance falls on a holiday or weekend, the date for performance shall automatically be extended to the next business day.

IN WITNESS WHEREOF, the parties have executed and delivered this Agreement in duplicate on the day and year first above written.

SELLER:

BOEHMER AUTOMOTIVE INC.
 D/b/a Bochmer Chevrolet Sales, Inc.

By: 
 Name: Steven K. Boehmer
 Its: CEO

PURCHASER:

WAUCONDA ASSOCIATES, L.L.C.

By: 
 Name: CHRISTOPHER VIGER
 Its: VP-FINANCE

EXHIBIT A
LEGAL DESCRIPTION

(TO BE INSERTED)

PIN: _____

Commonly known as: _____

EXHIBIT B

PROMISSORY NOTE

\$400,000

**June __, 2012
Chicago, Illinois**

FOR VALUE RECEIVED, WAUCONDA ASSOCIATES, L.L.C., an Illinois limited liability company ("Maker") hereby promises to pay to BOEHMER AUTOMOTIVE INC., an Illinois corporation f/k/a Boehmer Chevrolet Sales, Inc. ("Holder"), the principal sum of Four Hundred Thousand (\$400,000.00) Dollars payable in accordance with the terms hereof.

1. Interest. The unpaid principal amount of this Note shall bear interest at the rate of 0.75% per annum and shall be paid annually as set forth below.

2. Payments.

(a) Principal and Interest. Maker shall make the following payments of principal and interest:

<u>Date</u>	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
June __, 2013	\$100,000.00	\$3,000.00	\$103,000.00
June __, 2014	\$100,000.00	\$2,250.00	\$102,250.00
June __, 2015	\$100,000.00	\$1,500.00	\$101,500.00
June __, 2016	\$100,000.00	\$750.00	\$100,750.00

(b) Prepayment. Maker may not prepay the Note in whole or in part.

(c) Payment Address. All payments due under this Note shall be made to the Holder at the following address:

Boehmer Automotive Inc.
c/o Steven K. Boehmer
416 W. Liberty St.
Wauconda, IL 60084

or at such other place as Holder shall designate in writing to Maker.

3. Other Documents. This Note constitutes the Note described in, and is issued pursuant to, a Purchase and Sale Agreement, dated as of February __, 2012 (the "PSA"), by and among Maker and Holder. Reference is hereby made to the PSA.

4. Events of Default; Remedies.

(a) **Event of Default.** The following shall be an "Event of Default" under this Note:

(i) Maker shall fail to make a payment under this Note within ten (10) days after the date when due.

(b) **Remedies.** Upon the occurrence of an Event of Default:

(i) Holder may, upon written notice to Maker effective upon receipt by Maker, declare the entire amount of unpaid principal and accrued and unpaid interest under this Note immediately due and payable; and

(ii) Maker shall pay all fees and expenses incurred by Holder, including the reasonable fees of counsel, in connection with the enforcement or protection of Holder's rights under this Note.

5. **Waiver.** Maker hereby waives presentment for payment, protest and demand, notice of protest and demand.

**MAKER:
WAUCONDA ASSOCIATES, L.L.C.**

By: _____

Its: _____

The undersigned, Laura Zung and Christopher Vicere, both have reviewed the terms of the foregoing Note and both hereby personally guaranty, jointly and severally, all payments, including all principal and interest thereon, obligations and liabilities of Maker on the Note. Holder shall have no obligation to proceed against or exhaust its remedies against Maker as a condition to Laura Zung's and Christopher Vicere's obligations hereunder. Guarantors acknowledge that the Holder has given sufficient consideration for these Guarantees by entering into the PSA (as defined herein).

Laura Zung

Christopher Vicere

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(CONTINUED III)**

Operating Identity/Licensee

- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.

Wauconda Healthcare and Rehabilitation Centre, LLC is and will be the operator of Wauconda Healthcare and Rehabilitation Centre. Its Certificate of Good Standing is appended as **ATTACHMENT-3A**.

Persons with five percent or greater interest in this licensee are:

The Estate of Cynthia Chow:	33%
Laurence Zung:	33%
Ronald Zung:	33%

ATTACHMENT-3



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 01, 2000, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1212402424

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of MAY A.D. 2012

Jesse White

SECRETARY OF STATE

ATTACHMENT - 3A

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(CONTINUED IV)**

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

Wauconda Healthcare and Rehabilitation Centre has no related entities through traditional corporate organizational structures. However, there are two related entities through the individuals listed who have ownership five percent or greater percentage in the licensee entity. Therefore, Oak Brook Health Care Centre, Ltd and Norridge Nursing Center, Inc. are related facilities. Please refer to **ATTACHMENT-4A** for the informal organizational relationship chart.

ATTACHMENT-4

Wauconda Healthcare and Rehabilitation Centre, LLC Ownership Details:

Wauconda Healthcare and Rehabilitation Centre

- Estate of Cynthia Chow 33.3%
 - Julie Brum
 - Jennifer Chow
- Laurence Zung 33.3%
- Ronald Zung 33.3%

Other Facilities with Overlapping Ownership:

Oak Brook Healthcare Centre, Ltd.:

- Laurence Zung: 50%
- Estate of Cynthia Chow
 - Julie Brum: 25%
 - Jennifer Chow: 25%

Norridge Nursing Center, Inc.

- Laurence Zung: 40%
- Julie Brum: 20%
- Jennifer Chow: 20%

Wauconda Healthcare and Rehabilitation Centre, LLC

- Estate of Cynthia Chow: 33.3%
 - Julie Brum
 - Jennifer Chow
- Laurence Zung: 33.3%
- Ronald Zung: 33.3%

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(CONTINUED V)**

Flood Plain Requirements

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.idph.state.il.us/about/hfpb.htm>).

The proposed project is an addition of skilled beds by new construction on the existing Wauconda Healthcare and Rehabilitation Centre. A letter and a flood plain map identifying that the area is not within a special flood zone area is appended as **ATTACHMENT-5A**.

ATTACHMENT-5



300 N. State Street Suite 4104 Chicago IL 60610
P. 312.802.2401 F. 312.923.9177
2401inc@speedsite.com

April 25, 2012

Reference: Wauconda Healthcare – Flood Plain Analysis

IDPH Provider Number – 145887

Flood Plain Analysis:

To whom this may concern,

Please find attached the flood plain map identifying any areas that would be located within the 100 or 500 year flood plain.

This expansion *is not* within these areas.

Thank you for your time in reviewing this.

Sincerely,

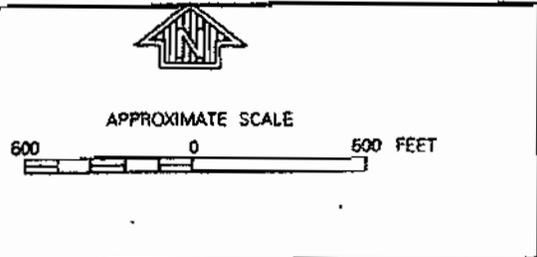
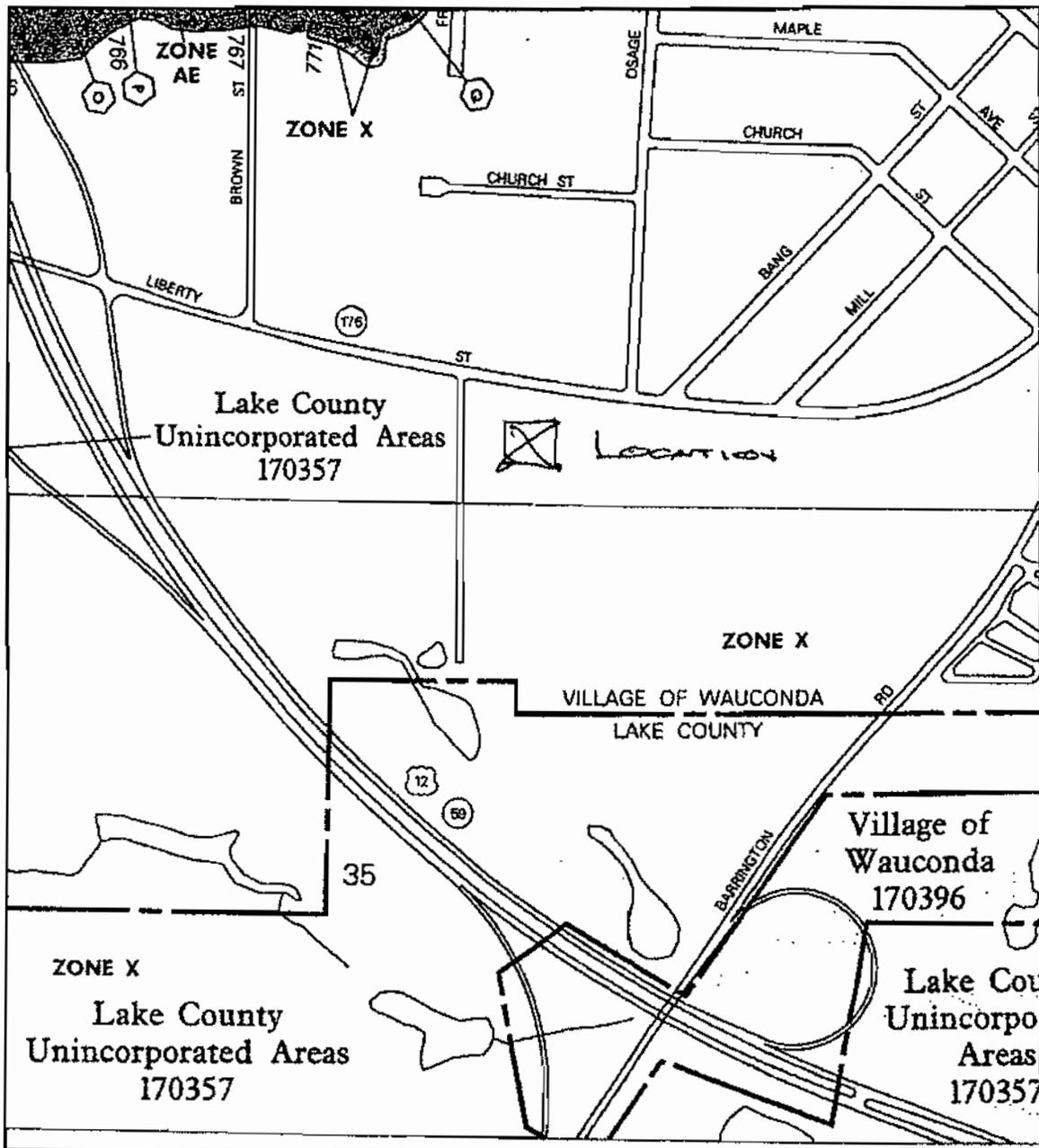
A handwritten signature in black ink that reads 'R. L. Kane'. The signature is written in a cursive style with a long horizontal stroke at the end.

Randal L. Kane, Architect

2401 Incorporated

ATTACHMENT - 5A

300 N State Street #4104 Chicago Illinois 60610
P. 312.802.2401 F. 312.923.9177 2401inc@speedsite.com



NATIONAL FLOOD INSURANCE PROGRAM

FIRM
FLOOD INSURANCE RATE MAP
LAKE COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 119 OF 285

(SEE MAP INDEX FOR PANELS NOT PRINTED)

CONTAINS

COUNTY	SHEET	PANEL	SHEET
LAKE COUNTY	119	119	5
WAUCONDA, VILLAGE OF	119	119	5

Note: If other than the MAP NUMBER shown below should be used when ordering map sheets, the COUNTY NUMBER should also be used to identify the sheets to be ordered.

MAP NUMBER
17097C0119 G

MAP REVISED:
SEPTEMBER 7, 2000



Federal Emergency Management Agency

This is an official copy of a portion of the above referenced flood map. It was extracted using FIRM On-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For the latest product information about National Flood Insurance Program flood maps check the FEMA Flood Map Store at www.nfip.fema.gov

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(CONTINUED VI)**

Historic Resources Preservation Act Requirements

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

Appended as ATTACHMENT-6A is a letter to the Applicant from Ms. Anne E. Haaker, Deputy State Historic Preservation Officer from the Illinois Historic Preservation Agency determining that no historic, architectural or archaeological sites exist within the project area.

ATTACHMENT-6



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Lake County
Wauconda

CON - New Addition, Wauconda Healthcare and Rehab Centre
176 Thomas Court
IHPA Log #006051612

May 24, 2012

Gina Kniery
Charles H. Foley & Associates, Inc.
1638 S. MacArthur Blvd.
Springfield, IL 62704

Dear Ms. Kniery:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker
Deputy State Historic
Preservation Officer

ATTACHMENT-6A

Wauconda Soft Goods Information

Resident Rooms

Number	Item
57	Electric Beds
57	Bedside Table
57	Nightstand
57	Wardrobe
57	Couch
57	End Table
57	Recliner
57	Desk
57	Desk Chair
114	Lamp
114	High backed Chair
57	Dinette Table

Nurse's Stations

2	Desks
12	Chairs
2	Medcarts
2	Treatment Carts
6	Nurse's Station Computers
6	Medcart, Treatment Cart and Floating Laptops
2	Laptop Carts

Common Areas

3	3 Seater Couches
3	2 Seater Couches
6	End Tables
4	Game Tables
16	Game Table Chairs

Dining Rooms

15	Tables
60	Chairs

Therapy Room

2	Desks
12	Chairs
1	Conference Table
4	Chairs
2	Mat Tables
2	Stationary Bike
1	Treadmill
1	Stairs

Offices

8	Desks
8	Desk Chairs
2	Conference Room Table
12	Conference Chairs

Reception Area

2	Couches
2	End Tables
1	Reception Desk
1	Reception Chair
1	Sofa table

Exterior Spaces

5	Park Benches
---	--------------

ATTACHMENT - 7

green initiatives.....

May 2012

Reference: Wauconda Healthcare & Rehab Centre

- Green compliant site modification plan
- Construction pollution plan
- Low emission and fuel efficient vehicle encouragement – special parking
- Bicycle on site storage – alternative transportation
- Native plantings
- 50% reduction in landscape water consumption – water efficient landscaping
- Use of LED lighting – interior & exterior
- Storm water management
- Light pollution reduction – low level and controlled parking lighting
- Domestic water reduction
- Construction waste management and recycling
- Use of post consumer materials
- Outdoor air delivery monitoring
- Increased ventilation w/ use of energy recovery units – 40% to 60% energy savings
- Control of lighting systems
- Low emitting adhesives and sealants
- Low emitting paints & coatings

- Low emitting carpets
- High efficiency heating & cooling systems
- Outdoor views for 75 to 90% of spaces

2401 Incorporated of Illinois

ATTACHMENT - 7

300 N State Street #3812 Chicago Illinois 60654
P. 312.661.0140 F. 312.661.0270 2401architects@gmail.com

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS

Criterion 1110.230 - Project Purpose, Background and Alternatives

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable.

The Applicant for Wauconda Healthcare and Rehabilitation Centre is **Wauconda Associates, LLC** (owner) and **Wauconda Healthcare and Rehabilitation Centre, LLC** (operator/Licensee). As identified under organizational relationship section is that Oak Brook Health Care Centre and Norridge Nursing Center are related facilities.

A copy of each facility license is appended under **ATTACHMENT-11A**.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

The required documentation with regards to adverse action as defined under 1110.230.a)3)B is appended as **ATTACHMENT-11B**.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.

The above requested authorization for the Health Facilities and Services Review Board and the Department of Public Health access to information is appended as **ATTACHMENT-**

11C.

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

The Applicant has not submitted any other applications for permit; therefore, this item is not germane.

ATTACHMENT-11



State of Illinois 2080577

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The State of Illinois hereby certifies that the following person has been licensed under the provisions of the Illinois State Health Care Regulation and Code Act and is hereby authorized to engage in the activity as indicated below.

ARTHUR KOHRMAN, M.D.
ACTING DIRECTOR

ISSUE DATE	EXPIRES
05/10/2013	05/10/2015
LONG TERM CARE LICENSE	
SKILLED	1028
INTERMEDIATE	1028
UNRESTRICTED TOTAL BEDS	

BUSINESS ADDRESS

LICENSEE

OAKBROOK HEALTHCARE CENTRE, LTD.

OAKBROOK HEALTHCARE CENTRE

2013 NICHESSE ROAD

OAKBROOK, ILL 60453

EFFECTIVE DATE 05/10/2013

THE STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 20662482 Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

LONG CONOVER, AND ASSOCIATES
ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	TO NUMBER
11/03/2012	EGDE	0040453
LONG TEAM CARE LICENSE SKILLED INTERMEDIATE 072		
UNRESTRICTED 176 TOTAL RECS		

BUSINESS ADDRESS

FAIRMONT CARE CENTER, INC.
FAIRMONT CARE CENTRE
5061 NORTH PULASKI ROAD
CHICAGO, ILLINOIS 60630

State of Illinois 20662482 Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	TO NUMBER
11/03/2012	EGDE	0040453
LONG TEAM CARE LICENSE SKILLED INTERMEDIATE 072		
UNRESTRICTED 176 TOTAL RECS		

10/19/11
FAIRMONT CARE CENTRE
5061 NORTH PULASKI ROAD
CHICAGO IL 60630

FEE RECEIPT NO.



State of Illinois 2087040
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

CRAIG CONOVER, M.D.
ACTING DIRECTOR

Issued under the authority of
 The State of Illinois
 Department of Public Health

EXPIRATION DATE	CATEGORY	U.S. NUMBER
11/30/2013	860E	0044859
LONG TERM CARE LICENSE SKILLED		
UNRESTRICTED 135 TOTAL BEDS		

BUSINESS ADDRESS
 LICENSEE

NAUCONDA HEALTHCARE AND REHABILITATION CENT,
 NAUCONDA HEALTHCARE AND REHAB
 176 THOMAS COURT
 NAUCONDA
 EFFECTIVE DATE: 12/01/11

By the Department of Public Health, State of Illinois

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2030590
 Department of Public Health
 LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	BY NUMBER
08/25/2011	BBBE	0032011

LONG TERM CARE LICENSE
 SKILLED
 UNRESTRICTED 292 TOTAL BEDS

03/29/11
 NORRIDGE HEALTH & REHAB CENTRE
 7001 WEST CULLUM
 NORRIDGE IL 60706
 FEE RECEIPT NO.

State of Illinois 2030590
 Department of Public Health
 LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate complies with the provisions of the Illinois Statutes and/or Rules and regulations and is hereby authorized to engage in the activity as indicated below.

GARON T. ARNOLD, M.D.
 DIRECTOR
 Licensed under the authority of
 The State of Illinois
 Department of Public Health

EXPIRATION DATE	CATEGORY	BY NUMBER
04/27/2013	BBBE	0032011

LONG TERM CARE LICENSE
 SKILLED
 UNRESTRICTED 292 TOTAL BEDS

BUSINESS ADDRESS
 LICENSEE
 NORRIDGE HEALTH & REHAB CENTRE, INC.
 NORRIDGE HEALTH & REHAB CENTRE
 7001 WEST CULLUM
 NORRIDGE IL 60706
 The above information is subject to change without notice by the State of Illinois - 457



HealthCare & Rehabilitation Centre
Trusted care. Peace of mind.

March 15, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

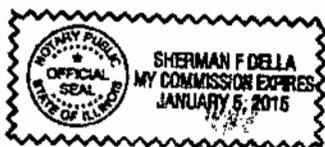
Dear Ms. Avery:

I hereby authorize the Health Facilities planning board and the Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted, including but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. I further authorize the Illinois Department of Public Health to obtain any additional documentation or information that said agency deems necessary for the review of this Application as it pertains to 1110.230.a).3)C.

Sincerely,

Christopher Vicere
Vice President - Finance

MARCH 15, 2012



ATTACHMENT-11B



HealthCare & Rehabilitation Centre

7001 West Cullom Avenue, Norridge, IL 60706
(708) 457-0700 FAX (708) 457-8852

May 1, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I hereby authorize the Health Facilities planning board and the Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted, including but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. I further authorize the Illinois Department of Public Health to obtain any additional documentation or information that said agency deems necessary for the review of this Application as it pertains to 1110.230.a).3)C.

Sincerely,


Christopher Vicere
Vice President – Finance

Subscribed and Sworn to me

this 1 day of MAY, 2012


Notary Public



A Member of the Lancaster Health Group
Trusted Care. Peace of Mind.

ATTACHMENT-11B


Oak Brook
HealthCare

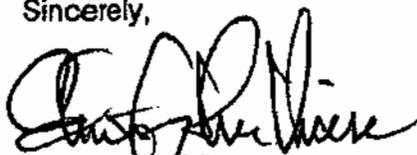
May 1, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

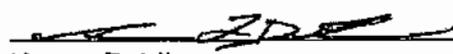
I hereby authorize the Health Facilities planning board and the Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted, including but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. I further authorize the Illinois Department of Public Health to obtain any additional documentation or information that said agency deems necessary for the review of this Application as it pertains to 1110.230.a).3)C.

Sincerely,


Christopher Vicere
Vice President – Finance

Subscribed and Sworn to me

this 1 day of MAY, 2012


Notary Public



ATTACHMENT-11B

2013 Midwest Road • Oak Brook, IL 60523 • Phone 630-495-0220 • Fax 630-629-5760



HealthCare & Rehabilitation Centre
Trusted care. Peace of mind.

March 15, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

Please be advised that no adverse action as defined under 1110.230.a).3)B has been taken against the Applicant or against any health care facility owned or operated by the Applicant, directly or indirectly, within three years preceding the filing of the Certificate of Need Application.

Sincerely,

Christopher Vicere
Vice President – Finance

Subscribed and Sworn to me

this 15 day of MARCH, 2012

Notary Public



ATTACHMENT-11C



HealthCare & Rehabilitation Centre

7001 West Cullom Avenue, Norridge, IL 60706
(708) 457-0700 FAX (708) 457-8852

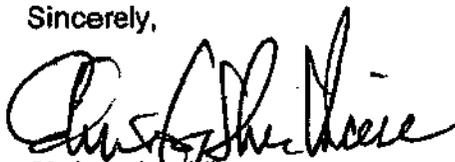
May 1, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

Please be advised that no adverse action as defined under 1110.230.a).3)B has been taken against the Applicant or against any health care facility owned or operated by the Applicant directly or indirectly, within three years preceding the filing of the Certificate of Need Application.

Sincerely,


Christopher Vicere
Vice President - Finance

Subscribed and Sworn to me

this 1 day of May, 2012


Notary Public



A Member of the Lancaster Health Group
Trusted Care. Peace of Mind.

ATTACHMENT - 11C


Oak Brook
HealthCare

May 1, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

Please be advised that no adverse action as defined under 1110.230.a).3)B has been taken against the Applicant or against any health care facility owned or operated by the Applicant directly or indirectly, within three years preceding the filing of the Certificate of Need Application.

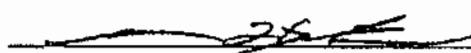
Sincerely,



Christopher Vicere
Vice President – Finance

Subscribed and Sworn to me

this 1 day of MAY, 2012


Notary Public



ATTACHMENT-11C

2013 Midwest Road • Oak Brook, IL 60523 • Phone 630-495-0220 • Fax 630-629-5760

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued II)

Criterion 1110.230 - Project Purpose, Background and Alternatives

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

This project is for the modernization and expansion of the existing nursing category of service known as Wauconda Healthcare and Rehabilitation Centre. As outlined in the project's narrative description, the renovations to the existing space include; the expansion and modernization of the existing kitchen and dining areas; the conversion of existing space into a bistro, library, game area, coffee and juice bar, and a computer café; and the reduction of beds within the rooms as outlined above to improve the overall number of private rooms in the facility. The needed facility improvements cannot all be accomplished within the parameters of the existing building footprint; therefore, the addition will include: a new and expanded therapy department; a consolidation of the administration space; additional employee and new employee training space; a new main entrance; and new and separate covered ambulance entrance. Additionally, the modernization and expansion of the existing services and their respective areas requires the Applicant to also expand the potential income base to make the project more financially viable. To accomplish this the project is proposing to replace 17 existing beds in the newly constructed addition and add 40 additional nursing beds to total bed compliment of 135 existing capacity.

This project will provide health services to improve the health care or well-being of the market area population to be served by alleviating the pressure

Calendar Year	Licensed Beds	Patient Days	Occup. %
2010	135	43,871	89%
2009	135	40,673	83%
2008	125	39,873	87%
2007	125	41,382	91%
2006	125	42,975	94%
2005	<u>117</u>	<u>40,238</u>	<u>94%</u>
Ave:	127	249,012	90%

ATTACHMENT-12

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued III)

Criterion 1110.230 - Project Purpose, Background and Alternatives

PURPOSE OF PROJECT (Continuation ii)

of the healthy utilization of the existing facility and addressing the need identified for additional nursing care beds according to the State's Inventory of Health Care Facilities and Services and Need Determinations that calculates a need for an additional 576 nursing care beds (total need for 5,275 beds – total inventory of 4,699 beds = a need for 576 more nursing care beds). Table One on the page above provides the past six year use rates for Wauconda Healthcare and Rehabilitation Centre. In addressing the issues of: the need to modernize; the high facility utilization; and the State's calculated need for additional nursing care beds in the Lake County Planning Area, the Applicant proposes to improve the well-being and healthcare of the market area population.

2. Define the planning area or market area, or other, per the applicant's definition.

The Planning Area is the Lake County Planning Area within Health Service Area VIII. The primary market area is proposed to also be the Lake County Planning Area along with the secondary market area being the 30-minute travel time contour. The last two years of admission data ending February 2012 reveals that 90 and 92 percent of the admissions into Wauconda Healthcare and Rehabilitation Centre come from within the 30-minute travel time contour of the existing site respectively for years 2011 and 2012.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

The existing issues that this project seeks to address are: 1. improve the overall number of private bed rooms within the facility, which is an objective set forth in the Health Facilities

ATTACHMENT-12

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued IV)

Criterion 1110.230 - Project Purpose, Background and Alternatives

PURPOSE OF PROJECT (Continuation iii)

Planning Act (20 ILCS 3960.Section 12.15); 2. modernization of the existing facility to ensure future marketability; 3. Alleviation of overall high utilization pressures.

4. Cite the sources of the information provided as documentation.

Appended as **ATTACHMENT-12A** are the past six years of IDPH Annual Facility Questionnaire forms documenting overall compliance with the State's occupancy target of 90%. Appended as **ATTACHMENT-12B**, is a copy of the State's May 16, 2012 update to its Inventory of Health Care Facilities and Services and Need Determinations. Appended as **ATTACHMENT-12C** is the admission data by month for the year ending February 2011 and February 2012. Appended as **ATTACHMENT-12D**, is the admission data by Zip Code within 30-minute travel time contour of the subject facility for the last two years ending February 2012.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

More important than the addition of nursing care beds to the licensed capacity, the proposed project includes the expansion of the facilities overall square footage and the replacement of 17 existing beds on-site. The project takes the existing square footage per bed of 288 gross square feet and increases it to 462 gross square feet (a 60.4 percent increase in overall size). The redistribution of space allows some areas to be replaced in the on-site new construction which in turn will allow existing square footage to be repurposed and renovated. The replacement of 17 of the existing nursing beds and the expansion of nursing services through the addition of 40 new nursing care beds accomplish two issues. The first is to provide greater number of private rooms throughout the facility; the addition that includes the replacement of 17

ATTACHMENT-12

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued V)

Criterion 1110.230 - Project Purpose, Background and Alternatives

PURPOSE OF PROJECT (Continuation IV)

beds will all be for private occupancy bed rooms. Each resident room will also have its own bathroom, further elevating the long-term marketability of the facility which is in addition to the a new and expanded therapy department; a consolidation of the administration space; additional employee and new employee training space; a new main entrance; and new and separate covered ambulance entrance all to be provided in newly constructed space. Private rooms are in keeping with cost reduction goals of CMMS by reducing rehospitalization, risk of infection and increasing positive outcomes. The second issue accomplished through this proposal is the alleviation of the overall high utilization while addressing the overwhelming need for additional nursing care beds in the Lake County Planning Area. The addition of 40-nursing care beds is modest when considering the need identified by the State is for 576 new nursing beds. Therefore, this project should more than conservatively accomplish the goals set forth.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.

This project's goal is to serve and improve physical environment of the existing residents of Wauconda Healthcare and Rehabilitation Centre and to better accommodate its staff as well as to build in flexibility in the Applicant's ability to serve additional residents of Lake County. The measurable outcome which will determine if this goal is met will be the Applicant's ability to maintain the optimal utilization upon the second full year of operation which should not appear to be an issue if the Applicant's utilization history is any indicator.

ATTACHMENT-12

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WAUCONDA HEALTHCARE CENTER WAUCONDA

WALCONDA HEALTHCARE CENTER
176 THOMAS COURT
WALCONDA, IL 60094
Reference Numbers Facility ID 009435
Health Service Area 008 Planning Service Area 087

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
Nursing Care	30	56	1	3	33	0	123
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
Shelter	0	0	0	0	0	0	0
TOTALS	30	56	1	3	33	0	123

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Total
Asian	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hispanic/Pac. Isl.	0	0	0	0	0
White	124	0	0	0	124
Race Unknown	0	0	0	0	0
Total	125	0	0	0	125

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
42.0%	28.0%	0.1%	3.1%	26.8%	0.0%
4,842,071	3,031,890	16,070	534,780	2,897,833	0
*Charity Expense does not include expenses which may be considered a community benefit.					

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WAUCONDA HEALTHCARE CENTER WAUCONDA

WALCONDA HEALTHCARE CENTER
176 THOMAS COURT
WALCONDA, IL 60094
Reference Numbers Facility ID 009435
Health Service Area 008 Planning Service Area 087

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Nephritis	7
Endometriosis	11
Blood Disorders	3
*Nervous System Non Alzheimer	17
Autism/Disorder	17
Mental Illness	0
Developmental Disability	43
Circulatory System	6
Respiratory System	6
Objective System	7
Genitourinary System Disorders	7
Stomach Disorders	1
Musculo-skeletal Disorders	5
Injuries and Poisonings	4
Other Medical Conditions	4
Non-Medical Conditions	0
TOTALS	125

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK BEDS	BEDS IN USE	ADMISSIONS	DISCHARGES
Nursing Care	135	135	135	135
Skilled Under 22	0	0	0	0
Intermediate DD	0	0	0	0
Skilled Care	0	0	0	0
TOTAL BEDS	135	135	135	135

BY LEVEL OF CARE PROVIDED AND PAYMENT SOURCE

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
69.2%	21.1%	0.0%	0.0%	0.0%	0.0%
927	211	0	0	0	0
TOTALS	1138	211	0	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 64	1	1	0	0	1	1	2
65 to 74	2	3	0	0	2	3	5
75 to 84	4	6	0	0	4	6	10
85+	14	21	0	0	14	21	35
TOTALS	31	51	0	0	31	51	82

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 64	1	1	0	0	1	1	2
65 to 74	2	3	0	0	2	3	5
75 to 84	4	6	0	0	4	6	10
85+	14	21	0	0	14	21	35
TOTALS	31	51	0	0	31	51	82

Source: Long-Term Care Facility Data for 2010, Illinois Department of Public Health, Health Systems Development

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 WAUKEMAR TERRACE

WAUKEMAR TERRACE
800 SOUTH LEWIS AVENUE
WAUKEMAR, IL 60066
Reference Numbers Facility ID 8074229
Health Service Area 008 Primary Service Area 007
Admission Restrictions
P.A. Details
Contact Person and Telephone
Jenny Pflaum
217-733-2551
Registered Agent Information
J. Michael Ebo
208 S. Fernham St.
Galesburg, IL 61401
FACILITY OWNERSHIP
NON-PROFIT CORPORATION
CONTINUING CARE COMMUNITY
LIFE CARE FACILITY

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	RESIDENTS
Neoplasms	1
Endocrine/Metabolic	0
Blood Disorders	0
Nervous System Non Alzheimer	0
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	5
Circulatory System	0
Respiratory System	0
Digestive System	0
Genitourinary System Disorders	0
Skin Disorders	0
Musculoskeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	5

LICENSED BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK
	LICENSED	BEDS	SET-UP	IN USE	REDS	REDS	REDS	REDS	REDS
Nursing Care	0	0	0	0	0	0	0	0	0
Skilled Under 22	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0
TOTAL BEDS	0	0	0	0	0	0	0	0	0

BY LEVEL OF CARE PROVIDED AND PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Private	Medicare	Medicaid	Other Public	Private	Charity
	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	CERTIFIED	CERTIFIED	CERTIFIED	CERTIFIED	CERTIFIED
Nursing Care	0	0	0	0	0	0	0	0	0	0	0
Skilled Under 22	0	0	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008

AGE GROUPS	Male	Female								
Under 18	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0
65 to 74	0	0	0	0	0	0	0	0	0	0
75 to 84	0	0	0	0	0	0	0	0	0	0
85+	0	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0	0

NET REVENUE BY PAYOR SOURCE (Fiscal Year Ends)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
42.8%	24.2%	0.0%	3.3%	29.7%	100.0%
4,320,570	2,439,763	2,204	332,782	2,991,067	10,085,895

Facility Notes: Added 40 nursing care beds; facility now has 135 nursing care beds.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 WAUKEMAR TERRACE

WAUKEMAR TERRACE
800 SOUTH LEWIS AVENUE
WAUKEMAR, IL 60066
Reference Numbers Facility ID 8074229
Health Service Area 008 Primary Service Area 007
Admission Restrictions
P.A. Details
Contact Person and Telephone
Jenny Pflaum
217-733-2551
Registered Agent Information
J. Michael Ebo
208 S. Fernham St.
Galesburg, IL 61401
FACILITY OWNERSHIP
NON-PROFIT CORPORATION
CONTINUING CARE COMMUNITY
LIFE CARE FACILITY

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	RESIDENTS
Neoplasms	1
Endocrine/Metabolic	0
Blood Disorders	0
Nervous System Non Alzheimer	0
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	5
Circulatory System	0
Respiratory System	0
Digestive System	0
Genitourinary System Disorders	0
Skin Disorders	0
Musculoskeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	5

LICENSED BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK
	LICENSED	BEDS	SET-UP	IN USE	REDS	REDS	REDS	REDS	REDS
Nursing Care	0	0	0	0	0	0	0	0	0
Skilled Under 22	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0
TOTAL BEDS	0	0	0	0	0	0	0	0	0

BY LEVEL OF CARE PROVIDED AND PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Private	Medicare	Medicaid	Other Public	Private	Charity
	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	CERTIFIED	CERTIFIED	CERTIFIED	CERTIFIED	CERTIFIED
Nursing Care	0	0	0	0	0	0	0	0	0	0	0
Skilled Under 22	0	0	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008

AGE GROUPS	Male	Female								
Under 18	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0
65 to 74	0	0	0	0	0	0	0	0	0	0
75 to 84	0	0	0	0	0	0	0	0	0	0
85+	0	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0	0

NET REVENUE BY PAYOR SOURCE (Fiscal Year Ends)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
42.8%	24.2%	0.0%	3.3%	29.7%	100.0%
4,320,570	2,439,763	2,204	332,782	2,991,067	10,085,895

Facility Notes: Added 40 nursing care beds; facility now has 135 nursing care beds.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 Wauconda Healthcare & Rehab Wauconda

Wauconda Healthcare & Rehab		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
176 Thomas Court		Aggravated Anti-Social	1	DIAGNOSIS	
Wauconda, IL 60084		Chronic Alcoholism	1	Neoplasms	
Reference Numbers	Facility ID 8008435	Developmentally Disabled	1	Endocrine/Metabolic	
Health Service Area 006	Planning Service Area 007	Drug Addiction	1	Blood Disorders	
Administrator		Medical Recipient	0	Nervous System Non Alcoholic	
Kathy Berg		Medicare Recipient	0	Alzheimer Disease	
		Mental Illness	1	Mental Illness	
		Non-Ambulatory	0	Developmental Disability	
Contact Person and Telephone		Non-Mobile	0	Circulatory System	
Kathy Berg		Public Aid Recipient	0	Respiratory System	
847-526-6651		Under 65 Years Old	0	Digestive System	
	Date Completed 5/8/2009	Unable to Self-Medicat	0	Genitourinary System Disorders	
Registered Agent Information		Ventilator Dependent	1	Skin Disorders	
		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	
		Other Restrictions	0	Injuries and Poisonings	
		No Restrictions	0	Other Medical Conditions	
		Note: Reported restrictions directed to '1'		Non-Medical Conditions	
				TOTALS	
				106	

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS				ADMISSIONS AND DISCHARGES - 2008				
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2008	Total Admissions 2008
Nursing Care	125	125	125	106	19	120	40	114	263
Skilled Under 22	0	0	0	0	0	0	0	0	271
Intermediate DD	0	0	0	0	0	0	0	0	106
Sheltered Care	0	0	0	0	0	0	0	0	
TOTAL BEDS	125	125	125	106	19	120	40		

LEVEL OF CARE	FACILITY UTILIZATION - 2008											
	BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
	Medicare		Medicaid		Other Public		Private Insurance		Private/Charity Care		Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	9007	20.5%	19220	131.3%	477	747	10422	0	39673	87.2%	87.2%	
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%	
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%	
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%	
TOTALS	9007	20.5%	19220	131.3%	477	747	10422	0	39673	87.2%	87.2%	

AGE GROUPS	RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008										
	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 10	0	0	0	0	0	0	0	0	0	0	0
10 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 54	1	0	0	0	0	0	0	0	1	0	1
55 to 64	0	3	0	0	0	0	0	0	0	3	3
65 to 74	5	0	0	0	0	0	0	0	5	0	5
75 to 84	11	14	0	0	0	0	0	0	11	14	25
85+	11	55	0	0	0	0	0	0	11	55	66
TOTALS	28	78	0	0	0	0	0	0	28	78	106

Source: Long-Term Care Facility Questionnaire for 2008, Illinois Department of Public Health, Health Systems Development

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 Wauconda Healthcare & Rehab Wauconda

Wauconda Healthcare & Rehab		RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE		AVERAGE DAILY PAYMENT RATES							
176 Thomas Court		LEVEL OF CARE	Medicare	Medicaid	Other Public Insurance	Private Pay	Charity Care	TOTALS	LEVEL OF CARE	SINGLE	DOUBLE
Wauconda, IL 60084		Nursing Care	26	45	0	6	28	0	Nursing Care	242	277
Reference Numbers	Facility ID 8008435	Skilled Under 22	0	0	0	0	0	0	Skilled Under 22	0	0
Health Service Area 006	Planning Service Area 007	ICF/DD	0	0	0	0	0	0	Intermediate DD	0	0
Administrator		Sheltered Care	0	0	0	0	0	0	Sheltered	0	0
Kathy Berg		TOTALS	26	45	0	6	28	0	106		

RACE	RESIDENTS BY RACIAL/ETHNICITY GROUPING					STAFFING	
	Nursing	Skilled 22	ICF/DD	Sheltered	Total	EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Asian	0	0	0	0	0	Administrators	1.00
Amer. Indian	0	0	0	0	0	Physicians	0.00
Black	0	0	0	0	0	Director of Nursing	1.00
Hispanic/Pac. Isl.	0	0	0	0	0	Registered Nurses	20.00
White	106	0	0	0	106	LPNs	3.00
Race Unknown	0	0	0	0	0	Certified Assist.	50.00
Total	106	0	0	0	106	Other Health Staff	1.00
						Non-Health Staff	60.00
						Total	142.00

LEVEL OF CARE	NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)						TOTALS	Charity Care Expense	Charity Care Expense as % of Total Net Revenue
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care			
Nursing Care	44.7%	26.7%	0.0%	2.6%	24.0%	100.0%	0	0.0%	
Skilled Under 22	4,228,799	2,717,821	0	250,431	2,267,053	9,480,904	0	0.0%	

Source: Long-Term Care Facility Questionnaire for 2008, Illinois Department of Public Health, Health Systems Development

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ATTACHMENT - 12A

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2007 Wauconda HealthCare & Rehab Wauconda

Wauconda HealthCare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID 8009459
Health Services Area 008 Planning Services Area 007

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Insurance	Private Pay	Cherry Care	TOTALS
Nursing Care	28	57	3	29	0	114
Skilled Under 22	0	0	0	0	0	0
ICF/OD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	28	57	3	29	0	114

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/OD	Skilled	Shelter	Totals
Asian	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0
Black	0	0	0	0	0	0
Hispanic/Pac. Isl.	0	0	0	0	0	0
White	114	0	0	0	0	114
Pace Unknown	0	0	0	0	0	0
Total	114	0	0	0	0	114

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Cherry Care	TOTALS
50.2%	35.8%	0.0%	1.2%	22.0%	0.0%	100.0%
3,033,822	3,123,420	0	112,408	2,011,129	0	8,780,580

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2007 Wauconda HealthCare & Rehab Wauconda

Wauconda HealthCare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID 8009459
Health Services Area 008 Planning Services Area 007

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Neoplasms	4
Endocrine/Metabolic	0
Blood Disorders	0
Nervous System Non Alzheimer	9
Alzheimer Disease	0
Heart Disease	0
Developmental Disability	48
Circulatory System	7
Respiratory System	7
Digestive System	0
Genitourinary System Disorders	3
Skin Disorders	0
Musculo-skeletal Disorders	14
Injuries and Poisonings	13
Other Medical Conditions	2
Non-Medical Conditions	0
TOTALS	114

ADMISSIONS AND DISCHARGES - 2007

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	125	125	120
Skilled Under 22	0	0	0
ICF/OD	0	0	0
Skilled Care	0	0	0
TOTALS	125	125	120

FACILITY UTILIZATION - 2007

LEVEL OF CARE	Medicare	Medicaid	Other	Private Pay	Cherry Care	TOTAL
Nursing Care	7940	23517	9817	41382	0	81177
Skilled Under 22	0	0	0	0	0	0
ICF/OD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	7940	23517	9817	41382	0	81177

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other	Private Pay	Cherry Care	TOTAL
Nursing Care	7940	23517	9817	41382	0	81177
Skilled Under 22	0	0	0	0	0	0
ICF/OD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	7940	23517	9817	41382	0	81177

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2007

AGE GROUPS	Nursing Care	Skilled Under 22	ICF/OD	Skilled Care	Cherry Care	TOTAL
Under 18	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0
45 to 59	1	0	0	0	0	1
60 to 64	3	0	0	0	0	3
65 to 74	6	0	0	0	0	6
75 to 84	4	0	0	0	0	4
85+	9	0	0	0	0	9
TOTALS	22	0	0	0	0	22

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2007

AGE GROUPS	Nursing Care	Skilled Under 22	ICF/OD	Skilled Care	Cherry Care	TOTAL
Under 18	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0
45 to 59	1	0	0	0	0	1
60 to 64	3	0	0	0	0	3
65 to 74	6	0	0	0	0	6
75 to 84	4	0	0	0	0	4
85+	9	0	0	0	0	9
TOTALS	22	0	0	0	0	22

LONG-TERM CARE PROFILE-2008 Wauconda Healthcare & Rehab

Wauconda Healthcare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID 8009433
Health Service Area 008 Planning Service Area 097

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medical	Other	Public	Insurance	Private	Cherry	TOTALS
Nursing Care	11	73	0	0	0	26	0	110
Skilled Under 22	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0
Skilled Care	11	73	0	0	0	26	0	110

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLES	DOUBLES
Nursing Care	231	208
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Medicare	Medical	Other	Public	Insurance	Private	Cherry	TOTALS
Asian	0	0	0	0	0	0	0	0
Asian Indian	0	0	0	0	0	0	0	0
Black	0	0	0	0	0	0	0	0
Hispanic/Latino	0	0	0	0	0	0	0	0
White	110	0	0	0	0	0	0	110
Race Unknown	0	0	0	0	0	0	0	0
Total	110	0	0	0	0	0	0	110

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.00
LPNs	7.00
Certified Aide	48.00
Other Health Staff	7.00
Non-Health Staff	84.00
Totals	144.00

LONG-TERM CARE PROFILE-2008 Wauconda Healthcare & Rehab

Wauconda Healthcare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID 8009433
Health Service Area 008 Planning Service Area 097

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	1	DIAGNOSIS	110
Aggravated/Alcoholism	1	Nephritis	1
Chronic Alcoholism	4	Endocrine/Metabolic	4
Developmentally Disabled	1	Blood Disorders	1
Drug Abuse	0	Nervous System	12
Medically Restricted	0	Alzheimer Disease	0
Medicare Recipient	1	Mental Illness	11
Mental Illness	0	Developmental Disability	0
Non-Residential	0	Circulatory System	45
Non-Mobile	0	Respiratory System	4
Public Aid Recipient	0	Digestive System	2
Under 65 Years Old	0	Genitourinary System Disorders	4
Unable to Self-Maintain	1	Skin Disorders	0
Verbalizer Dependent	0	Musculoskeletal Disorders	24
Infectious Disease of Isolation	0	Injuries and Poisonings	2
Other Restrictions	0	Other Medical Conditions	0
No Restrictions	0	Non-Medical Conditions	0
None - Approval restrictions limited by 11	0	TOTALS	110

LICENSED BEDS, BEDS ON USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	BEDES	ADMISSIONS AND DISCHARGES - 2008						
	125	125	125	110	115	125	125	125	Residents on 1/1/2008
Skilled Under 22	0	0	0	0	0	0	0	0	111
Intermediate DD	0	0	0	0	0	0	0	0	164
Skilled Care	125	125	125	110	115	125	125	125	Total Admissions 2008
TOTAL BEDS	125	125	125	110	115	125	125	125	Total Discharges 2008

FACILITY UTILIZATION - 2008

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Other	TOTAL	Licensed Beds	Peak Beds	Full Time
	Medicare	Other	Medicare	Medicare	Other	Medicare
Nursing Care	6453	14.2%	27083	80.4%	8919	94.2%
Skilled Under 22	0	0.0%	0	0.0%	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0.0%
Skilled Care	6453	14.2%	27083	80.4%	8919	94.2%
TOTALS	6453	14.2%	27083	80.4%	8919	94.2%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008

AGE GROUPS	NURSING CARE	SKILLED UNDER 22	INTERMEDIATE DD	SKILLED CARE	TOTAL		
	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 59	2	3	0	0	2	3	5
60 to 74	0	1	0	0	0	1	1
75 to 84	4	4	0	0	4	4	8
85+	7	27	0	0	7	27	34
TOTALS	13	48	0	0	13	48	61

Source: Division of Health Systems Development
Illinois Department of Public Health
625 West Jefferson
Springfield, Illinois Phone: 217/782-5518

Does not include Alzheimer diagnoses
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LONG-TERM CARE PROFILE-2008 Wauconda Healthcare & Rehab

Wauconda Healthcare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID 8009433
Health Service Area 008 Planning Service Area 097

LICENSED BEDS, BEDS ON USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	BEDES	ADMISSIONS AND DISCHARGES - 2008						
	125	125	125	110	115	125	125	125	Residents on 1/1/2008
Skilled Under 22	0	0	0	0	0	0	0	0	111
Intermediate DD	0	0	0	0	0	0	0	0	164
Skilled Care	125	125	125	110	115	125	125	125	Total Admissions 2008
TOTAL BEDS	125	125	125	110	115	125	125	125	Total Discharges 2008

FACILITY UTILIZATION - 2008

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Other	TOTAL	Licensed Beds	Peak Beds	Full Time
	Medicare	Other	Medicare	Medicare	Other	Medicare
Nursing Care	6453	14.2%	27083	80.4%	8919	94.2%
Skilled Under 22	0	0.0%	0	0.0%	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0.0%
Skilled Care	6453	14.2%	27083	80.4%	8919	94.2%
TOTALS	6453	14.2%	27083	80.4%	8919	94.2%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2008

AGE GROUPS	NURSING CARE	SKILLED UNDER 22	INTERMEDIATE DD	SKILLED CARE	TOTAL		
	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 59	2	3	0	0	2	3	5
60 to 74	0	1	0	0	0	1	1
75 to 84	4	4	0	0	4	4	8
85+	7	27	0	0	7	27	34
TOTALS	13	48	0	0	13	48	61

Source: Division of Health Systems Development
Illinois Department of Public Health
625 West Jefferson
Springfield, Illinois Phone: 217/782-5518

Does not include Alzheimer diagnoses
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2005 ILLINOIS DEPARTMENT OF PUBLIC HEALTH LONG-TERM CARE FACILITY PROFILES

Reference Numbers DR 097 097 009435
 Wauconda Healthcare & Rehab
 176 Thomas Court
 Wauconda, IL 60084
 Administrator
 Sandra Borcz
 Contact Person and Telephone
 Judi Borcz
 847-526-5551
 Registered Agent Information
 SCHWARTZ, LAWRENCE Y
 7366 NORTH LINCOLN, SUITE 404
 LINCOLNWOOD, IL 60084
 FACILITY OWNERSHIP
 LIMITED LIABILITY CO

ADMISSION RESTRICTIONS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addictions	1
Medicaid Recipient	11
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Other Restrictions	0
No Restrictions	0
Note: 1 equals restriction used by facility	
	TOTALS 114

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS		PEAK BEDS IN USE		MEDICARE CERTIFIED	MEDICAID CERTIFIED
	BEDS	SET-UP	BEDS	SET-UP		
Nursing Care	117	117	117	114	125	125
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTAL BEDS	117	117	117	114	125	125

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2005

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	2	0	0	0	0	0	0	3	2	5
60 to 64	0	1	0	0	0	0	0	0	0	1	1
65 to 74	6	5	0	0	0	0	0	0	6	5	11
75 to 84	9	27	0	0	0	0	0	0	9	27	36
85 Over	10	51	0	0	0	0	0	0	10	51	61
TOTALS	28	86	0	0	0	0	0	0	28	86	114

PATIENT DAYS OF CARE - 2005 BY LEVEL OF CARE AND PATIENT TYPE

LEVEL OF CARE	Medicare			TOTAL	Licenses		Set Up	
	Medicaid	Other	Dec. Pct.		Occ. Pct.			
Nursing Care	4958	28647	6673	40238	94.2	94.2		
Skilled 22	0	0	0	0	0.0	0.0		
ICF/DD	0	0	0	0	0.0	0.0		
Shelter	0	0	0	0	0.0	0.0		
TOTALS	4958	28647	6673	40238	94.2	94.2		

PATIENT DAYS BY PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid	
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.
Nursing	4958	10.9	28647	62.8
Skilled 22	0	0.0	0	0.0
ICF/DD	0	0.0	0	0.0
TOTALS	4958	10.9	28647	62.8

Source: Health Systems Development
 Illinois Department of Public Health
 525 West Jefferson
 Springfield, Illinois Phone: 217/782-3518

Note: Numbers preceding each section refer to the number of the question in the survey.
 *Does not include Alzheimer diagnoses.

2005 ILLINOIS DEPARTMENT OF PUBLIC HEALTH LONG-TERM CARE FACILITY PROFILES

Wauconda Healthcare & Rehab 008 009435

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other	Public Insurance	Private Pay	Charity	TOTALS
Nursing Care	14	73	0	0	27	0	114
Skilled 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Shelter	0	0	0	0	0	0	0
TOTALS	14	73	0	0	27	0	114

ADMISSIONS AND DISCHARGES - 2005

A. Residencies on January 1, 2005 112

B. Total Admissions 2005 225

C. Total Discharges 2005 223

D. Residents on December 31, 2005 114

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled 22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian or Pacific Islander	0	0	0	0	0
White	114	0	0	0	114
Unknown	0	0	0	0	0
Total	114	0	0	0	114

ETHNICITY

ETHNICITY	Nursing	Skilled 22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Not Hispanic	114	0	0	0	114
Unknown	0	0	0	0	0
Total	114	0	0	0	114

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	217	185
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY AGE GROUP, SEX AND PAYMENT SOURCE - DECEMBER 31, 2005

AGE GROUPS	Medicare		Medicaid		Other Public Insurance		Private Pay		Charity		TOTALS		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	3	2	0	0	0	0	0	0	3	2	5
60 to 64	0	0	0	0	0	0	0	0	1	0	0	0	1
65 to 74	1	2	5	2	0	0	0	0	1	0	6	5	11
75 to 84	1	2	7	17	0	0	0	1	3	0	9	27	36
85 Over	3	5	5	32	0	0	0	8	2	14	0	10	51
TOTALS	5	9	20	51	0	0	0	3	24	0	28	86	114

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	15.00
LPNs	3.00
Certified Aides	39.00
Other Health Staff	8.00
Non-Health Staff	41.00
Total	108.00

FACILITY NOTES

Bed Change 5/9/2005
 Added eight nursing care beds, total now 125 nursing care beds.

Source: Health Systems Development
 Illinois Department of Public Health
 525 West Jefferson
 Springfield, Illinois Phone: 217/782-3516

Note: Numbers preceding each section refer to the number of the question in the survey.
 *Does not include Alzheimer diagnoses.

ATTACHMENT - 12A

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 05/16/2012

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION
CHANGES TO GENERAL LONG-TERM CARE				
Health Service Area 001				
Boone	CHOW	01/10/2012	MAPLE CREST CARE CENTRE, BELVIDERE	Change of ownership occurred.
	CHOW	01/10/2012	NORTHWOODS CARE CENTRE, BELVIDERE	Change of ownership occurred.
Lee	CHOW	01/09/2012	DIXON HEALTHCARE & REHAB CTR, DIXON	Change of ownership occurred.
Stephenson	P-11-064	10/11/2011	FREEPORT MEMORIAL HOSPITAL/SNU, FREEPORT	Permit issued to discontinue the 26 nursing care bed unit.
	P-11-064	10/11/2011	FREEPORT MEMORIAL HOSPITAL/SNU, FREEPORT	Project completed.
Winnebago	Closure	11/04/2011	ROCKFORD NURSING & REHAB CTR., ROCKFORD	Facility closed 11-4-2011, 97 nursing care beds removed from inventory.
	Bed Change	03/21/2012	FAIRHAVEN CHRISTIAN RET CENTER, ROCKFORD	Discontinued two sheltered care beds, total now 96 nursing care beds and 125 sheltered care beds.
Health Service Area 002				
Bureau/Putnam	Closure	06/10/2011	ORCHARD VIEW REHAB & HEALTHCAR, PRINCETON	Facility closed 06-10-2011, 123 nursing care beds removed from inventory.
	P-11-065	10/11/2011	MANOR COURT OF PRINCETON, PRINCETON	Permit issued to modernize facility. Will convert all 22 sheltered care beds to nursing care and add an additional 27 nursing care beds, total now 125 nursing care beds.
Fulton	Closure	07/29/2011	ASTORIA GARDEN & REHAB. CTR., ASTORIA	Facility closed 07-29-2011, 57 nursing care beds removed from inventory.
Henderson/Warren	Bed Change	04/23/2012	HENDERSON CO RETIREMENT CENTER, STRONGHURST	Added one nursing care bed, total now 60 nursing care beds. New
Knox	Bed Change	09/09/2011	KNOX COUNTY NURSING HOME, KNOXVILLE	Added 15 nursing care beds, total now 169 nursing care beds.
	Closure	03/27/2012	GOOD SAMARITAN KNOXVILLE, KNOXVILLE	Facility closed 03-27-2012, thirty nursing care beds removed from inventory. New
LaSalle	Name Change	10/01/2011	HERITAGE HEALTH-PERU, PERU	Name changed from Heritage Manor - Peru.
	Name Change	10/01/2011	HERITAGE HEALTH-STREATOR, STREATOR	Name changed from Heritage Manor - Streator.
	Name Change	10/01/2011	HERITAGE HEALTH-MENDOTA, MENDOTA	Name changed from Heritage Manor - Mendota.
	Name Change	10/01/2011	HERITAGE HEALTH-LASALLE, LASALLE	Name changed from Heritage Manor - LaSalle.
Peoria	Name Change	10/01/2011	HERITAGE HEALTH-CHILLICOTHE, CHILLICOTHE	Name changed from Heritage Manor - Chillicothe.
	P-11-063	10/11/2011	PROCTOR MEMORIAL HOSPITAL, PEORIA	Permit issued to discontinue 15 nursing care beds, total now 15 nursing care beds. Completion date will be 12-31-2011.
	P-11-063	12/31/2011	PROCTOR MEMORIAL HOSPITAL, PEORIA	Project completed.
	Bed Change	01/10/2012	PROCTOR MEMORIAL HOSPITAL, PEORIA	Added ten nursing care beds, total now 25 nursing care beds.
Tazewell	P-12-018	04/17/2012	PEKIN MEMORIAL HOSPITAL, PEKIN	Permit issued to discontinue 27 nursing care bed unit.
Woodford	Bed Change	02/01/2011	APOSTOLIC CHRISTIAN HOME, ROANOKE	Discontinued one nursing care bed, total now 60 nursing care beds.
	Name Change	02/01/2011	APOSTOLIC CHRISTIAN HOME, ROANOKE	Name changed from Apostolic - Roanoke.
	Name Change	10/01/2011	HERITAGE HEALTH-MINONK, MINONK	Name changed from Heritage Manor - Minonk.
	Name Change	10/01/2011	HERITAGE HEALTH-EL PASO, EL PASO	Name changed from Heritage Manor - El Paso.
	Bed Change	10/18/2011	SNYDER VILLAGE, METAMORA	Discontinued one nursing care bed, total now 104 nursing care beds.
Health Service Area 003				
Brown/Schuyler	Name Change	10/01/2011	HERITAGE HEALTH-MT. STERLING, MOUNT STERLING	Name changed from Heritage Manor - Mt Sterling.
	P-11-056	10/11/2011	SARAH CULBERTSON MEMORIAL HOSP, RUSHVILLE	Permit issued to discontinue the 29 nursing care bed unit.
	P-11-056	10/11/2011	SARAH CULBERTSON MEMORIAL HOSP, RUSHVILLE	Project completed.
Christian	Name Change	10/01/2011	HERITAGE HEALTH-PANA, PANA	Name changed from Heritage Manor - Pana.
Hancock	Closure	08/22/2011	HANCOCK COUNTY NURSING HOME,	Facility closed 08-22-2011, 57 nursing care beds removed

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 05/16/2012

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION
			CARTHAGE	from inventory.
Logan	CHOW	01/13/2012	MAPLE RIDGE CARE CENTRE, LINCOLN	Change of ownership occurred.
Macoupin	Name Change	10/01/2011	HERITAGE HEALTH-STAUNTON, STAUNTON	Name changed from Heritage Manor - Staunton.
	Name Change	10/01/2011	HERITAGE HEALTH-GILLESPIE, GILLESPIE	Name changed from Heritage Manor - Gillespie.
	Name Change	10/01/2011	HERITAGE HEALTH-CARLINVILLE, CARLINVILLE	Name changed from Heritage Manor - Carlerville.
Menard	Closure	07/08/2011	MENARD CONVALESCENT CENTER, PETERSBURG	Facility closed 07-08-2011, 86 nursing care beds removed from inventory.
Montgomery	Name Change	10/01/2011	HERITAGE HEALTH-LITCHFIELD, LITCHFIELD	Name changed from Heritage Manor - Litchfield.
Morgan/Scott	Closure	08/26/2011	CARE CENTER OF JACKSONVILLE, JACKSONVILLE	Facility closed 08-26-2011, 93 nursing care beds removed from inventory.
	Name Change	10/01/2011	HERITAGE HEALTH-JACKSONVILLE, JACKSONVILLE	Name changed from Barton W. Stone - Jacksonville.
Sangamon	Name Change	10/01/2011	HERITAGE HEALTH-SPRINGFIELD, SPRINGFIELD	Name changed from Heritage Manor - Springfield.
	P-08-080	12/16/2011	CONCORDIA VILLAGE, SPRINGFIELD	Facility licensed.
	Bed Change	12/19/2011	ST. JOSEPH'S HOME FOR AGED, SPRINGFIELD	Discontinued six sheltered care beds, total now 72 nursing care beds and 35 sheltered care beds.
Health Service Area 004				
Coies/Cumberland	CHOW	01/13/2012	MATTOON HEALTHCARE & REHAB CTR, MATTOON	Change of ownership occurred.
Ford	Name Change	10/01/2011	HERITAGE HEALTH-GIBSON CITY, GIBSON CITY	Name changed from Heritage Manor - Gibson City.
Livingston	Name Change	10/01/2011	HERITAGE HEALTH-DWIGHT, DWIGHT	Name changed from Heritage Manor - Dwight.
McLean	Name Change	10/01/2011	HERITAGE HEALTH-NORMAL, NORMAL	Name changed from Heritage Manor - Normal.
	Name Change	10/01/2011	HERITAGE HEALTH-BLOOMINGTON, BLOOMINGTON	Name changed from Heritage Manor - Bloomington.
Macon	Name Change	10/01/2011	HERITAGE HEALTH-MOUNT ZION, MOUNT ZION	Name changed from Heritage Manor - Mount Zion.
	CHOW	01/10/2012	ASPEN RIDGE CARE CENTER, DECATUR	Change of ownership occurred.
	CHOW	01/10/2012	MCKINLEY COURT, DECATUR	Change of ownership occurred.
	Bed Change	01/15/2012	HEARTLAND OF DECATUR, DECATUR	Added five nursing care beds, total now 117 nursing care beds.
	P-12-005	04/17/2012	HICKORYPOINT CHRISTIAN VILLAGE, FORSYTH	Permit issued to add 17 nursing care beds, total now 64 nursing care beds.
Vermilion	Bed Change	01/09/2012	HAWTHORNE INN OF DANVILLE, DANVILLE	Discontinued six sheltered care beds and added six nursing care beds, total now 76 nursing care beds and 64 sheltered care beds.
Health Service Area 005				
Franklin	CHOW	01/18/2012	STONEBRIDGE SENIOR LIVING CTR, BENTON	Change of ownership occurred.
Lawrence	Bed Change	03/22/2012	UNITED METHODIST VILLAGE, LAWRENCEVILLE	Discontinued 20 nursing care beds, total now 143 nursing care beds.
Marion	CHOW	01/18/2012	FRIENDSHIP HOUSE OF CENTRALIA, CENTRALIA	Change of ownership occurred.
	CHOW	01/18/2012	FIRESIDE HOUSE OF CENTRALIA, CENTRALIA	Change of ownership occurred.
Randolph	Name Change	01/26/2012	RED BUD REGIONAL CARE, RED BUD	Name changed from Red Bud Nursing Home.
White	Bed Change	01/24/2012	ENFIELD REHAB & H.C.C., ENFIELD	Discontinued two nursing care beds, total now 47 nursing care beds.
Health Service Area 006				
Planning Area 6-A	Closure	05/06/2011	WINCREST NURSING CENTER, CHICAGO	Facility closed 05-06-2011, 82 nursing care beds removed from inventory.
	CHOW	10/01/2011	CHALET LIVING & REHAB CENTER, CHICAGO	Change of ownership occurred.
	Name Change	10/01/2011	CHALET LIVING & REHAB CENTER, CHICAGO	Name changed from Sherwin Manor Nursing Center.
	Bed Change	11/10/2011	HERITAGE HEALTHCARE CENTER, CHICAGO	Discontinued one nursing care bed, total now 127 nursing care beds.
Planning Area 6-C	Bed Change	09/26/2011	WASHINGTON & JANE SMITH COMM.,	Discontinued two nursing care beds, total now 101

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 05/16/2012

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION
			CHICAGO	nursing care beds.
			Health Service Area 007	
Planning Area 7-A	Bed Change	09/08/2011	MOORINGS HEALTH CENTER, THE, ARLINGTON HTS	Discontinued 23 sheltered care beds, total now 116 nursing care beds and 44 sheltered care beds.
	Bed Change	09/29/2011	GREEK AMERICAN REHAB & CARE CT, WHEELING	Discontinued six nursing care beds, total now 198 nursing care beds.
	Bed Change	03/16/2012	ST. JOSEPH'S HOME FOR ELDERLY, PALATINE	Discontinued one nursing care bed, total now 59 nursing care beds and seven sheltered care beds.
Planning Area 7-B	Closure	10/17/2011	HOLY FAMILY NSG. & REHAB CTR., DES PLAINES	Facility closed 10-17-2011, 251 nursing care beds removed from inventory.
Planning Area 7-C	P-11-055	10/11/2011	TRANS. CARE CTR OF NAPERVILLE, NAPERVILLE	Permit issued to establish a 120 bed nursing care facility.
	Bed Change	10/13/2011	BEACON HILL, LOMBARD	Added two nursing care beds, total now 110 nursing care beds.
	CHOW	01/03/2012	BURGESS SQUARE, WESTMONT	Change of ownership occurred.
	Bed Change	02/09/2012	DUPAGE CONVALESCENT HOME, WHEATON	Discontinued 140 nursing care beds, total now 368 nursing care beds.
	P-12-006	04/17/2012	ELMHURST MEMORIAL HOSPITAL, ELMHURST	Permit issued to discontinue the 38 bed nursing unit.
	P-07-071	04/17/2012	PARK PLACE CHRISTIAN VILLAGE, ELMHURST	Permit to establish a 37 bed nursing care facility with a CCRC limitation abandoned.
	P-12-007	04/17/2012	PARK PLACE CHRISTIAN VILLAGE, ELMHURST	Permit issued to establish a 37 bed nursing care facility.
	Name Change	04/17/2012	PARK PLACE CHRISTIAN VILLAGE, ELMHURST	Name changed from Park Place Christian Community.
Planning Area 7-D	CHOW	01/03/2012	OAKRIDGE HEALTHCARE CENTER, HILLSIDE	Change of ownership occurred.
	Name Change	01/03/2012	OAKRIDGE HEALTHCARE CENTER, HILLSIDE	Name changed from Oakridge Nursing & Rehab Ctr.
Planning Area 7-E	CHOW	01/06/2012	PERSHING GARDENS HC CENTER, STICKNEY	Change of ownership occurred.
	Name Change	01/06/2012	PERSHING GARDENS HC CENTER, STICKNEY	Name changed from Pershing Convalescent Center.
	City Change	01/06/2012	PERSHING GARDENS HC CENTER, STICKNEY	Corrected facility city to reflect Stickney rather than Berwyn.
	CHOW	01/13/2012	CRESTWOOD CARE CENTRE, CRESTWOOD	Change of ownership occurred.
	Bed Change	02/29/2012	MANORCARE OF SOUTH HOLLAND, SOUTH HOLLAND	Added 16 nursing care beds, total now 216 nursing care beds.
	P-11-104	04/17/2012	MCALLISTER NURSING & REHAB, TINLEY PARK	Permit issued to modernize facility and add 89 nursing care beds, total now 200 nursing care beds.
	P-12-003	04/17/2012	HOLY FAMILY VILLA, PALOS PARK	Permit issued to add 30 nursing care beds, total now 129 nursing care beds.
			Health Service Area 008	
Kane	Closure	03/01/2011	FOX RIVER PAVILION, AURORA	Facility closed 03-01-2011, 99 nursing care beds removed from inventory.
	Name Change	10/01/2011	HERITAGE HEALTH-ELGIN, ELGIN	Name changed from Heritage Manor - Elgin.
	CHOW	01/10/2012	COUNTRYSIDE CARE CENTER, AURORA	Change of ownership occurred.
Lake	Closure	03/11/2010	HELIA HEALTHCARE OF ZION, ZION	Facility closed 03-11-2010, 116 nursing care beds removed from inventory.
	Bed Change	10/01/2011	ROLLING HILLS MANOR NSG HOME, ZION	Discontinued 12 nursing care beds, total now 115 nursing care beds.
	Bed Change	11/04/2011	HILLCREST RETIREMENT VILLAGE, RND LAKE BEACH	Added two nursing care beds, total now 144 nursing care beds.
	P-11-009	11/29/2011	RADFORD GREEN, LINCOLNSHIRE	Forty-four permit beds licensed.
			Health Service Area 009	
Will	P-10-005	11/17/2011	SMITH CROSSING, ORLAND PARK	Licensed 16 nursing care permit beds.
	Bed Change	12/07/2011	SUNNY HILL NSG HOME OF WILL CO, JOLIET	Discontinued 20 nursing care beds, total now 280 nursing care beds.
	CHOW	01/10/2012	DEERBROOK CARE CENTRE, JOLIET	Change of ownership occurred.
	P-07-102	03/09/2012	ALDEN ESTATES OF SHOREWOOD, SHOREWOOD	Facility licensed.

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 05/16/2012

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION
Health Service Area 010				
Henry	Bed Change	07/12/2011	HAMMOND-HENRY DISTRICT HOSPITAL, GENESEO	Discontinued 18 nursing care beds, total now 38 nursing care beds.
Health Service Area 011				
Madison	Bed Change	10/28/2011	ST. CLARE'S HOSPITAL, ALTON	Discontinued four nursing care beds, total now 26 nursing care beds.
	Bed Change	01/17/2012	COLLINSVILLE REHAB & H.C.C., COLLINSVILLE	Discontinued two nursing care beds, total now 98 nursing care beds.
CHANGES TO SPECIALIZED LONG-TERM CARE				
Health Service Area 002				
LaSalle	Closure	03/28/2012	KNOX ESTATES, STREATOR	Facility closed 03-28-2012, 16 ICF/DD beds removed from the inventory.
Health Service Area 005				
Edwards/Wabash	Closure	04/01/2012	RIVER OAKS, MOUNT CARMEL	Facility closed 04-01-2012, 16 ICF/DD beds removed from the inventory.
Gallatin/Hamilton/	Closure	05/01/2012	BROOKE HILL, ELDORADO	Facility closed 05-01-2012, 16 ICF/DD beds removed from inventory. New
Lawrence	Closure	10/17/2011	HICKORY ESTATES, SUMNER	Facility closed 10-17-2011, 16 ICF/DD beds removed from inventory.
Union	Closure	12/28/2011	VILLAGE INN - COBDEN, COBDEN	Facility closed 12-28-2011, 16 ICF/DD beds removed from the inventory.
	Closure	04/02/2012	HOLLY HILL, ANNA	Facility closed 04-02-2012, 16 ICF/DD beds removed from the inventory.
Williamson	Closure	04/18/2011	INDEPENDENCE PLACE, HERRIN	Facility closed 04-18-2011, 16 ICF/DD beds removed from inventory.
Health Service Area 6-9				
Kane	Name Change	06/09/2011	BETHESDA LUTHERAN - MONTGOMERY, AURORA	Name changed from Bethesda Lutheran Home-Montgomery.
Kankakee	CHOW	07/01/2011	THOMAS HERBSTTRITT HOUSE, MOMENCE	Change of ownership occurred.
	CHOW	07/01/2011	THOMAS LOMBARD HOUSE, MOMENCE	Change of ownership occurred.
	Closure	03/31/2012	GRAVELIN SQUARE, BRADLEY	Facility closed 03-31-2012, 16 ICF/DD beds removed from the inventory.
Planning Area 7-D	CHOW	03/01/2012	BELLWOOD NURSING CENTER, BELLWOOD	Change of ownership occurred.
	Name Change	03/01/2012	BELLWOOD NURSING CENTER, BELLWOOD	Name changed from Aspire on Eastern.
Planning Area 7-E	Closure	04/10/2012	BETHSHAN II, PALOS HEIGHTS	Facility closed 04-10-2012, 16 ICF/DD beds removed from the inventory. New

LONG-TERM CARE BED INVENTORY UPDATES

09/16/2011 - 05/16/2012

LONG-TERM CARE GENERAL NURSING BED NEED

PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
HEALTH SERVICE AREA 001			
Boone	305	279	26
Carroll	187	170	17
DeKalb	757	742	15
Jo Daviess	231	155	76
Lee	299	342	(43)
Ogle	599	535	64
Stepherson	665	637	28
Whiteside	717	822	(105)
Winnebago	2,399	2,366	33
HEALTH SERVICE AREA 002			
Bureau/Putnam	429	373	56
Fulton	523	615	(92)
Henderson/Warren	245	218	27
Knox	823	950	(127)
LaSalle	1,364	1,419	(55)
McDonough	379	376	3
Marshall/Stark	346	427	(81)
Peoria	1,760	1,731	29
Tazewell	1,516	1,266	250
Woodford	655	592	63
HEALTH SERVICE AREA 003			
Adams	1,188	1,495	(307)
Brown/Schuyler	183	186	(3)
Calhoun/Pike	301	337	(36)
Cass	186	150	36
Christian	412	472	(60)
Greene	154	119	35
Hancock	190	184	6
Jersey	411	369	42
Logan	502	468	34
Macoupin	686	744	(58)
Mason	143	164	(21)
Menard	230	106	124
Montgomery	567	490	77
Morgan/Scott	573	561	12
Sangamon	1,344	1,254	90
HEALTH SERVICE AREA 004			
Champaign	1,037	908	129
Clark	290	255	35
Coles/Cumberland	759	939	(180)
DeWitt	219	190	29
Douglas	238	233	5
Edgar	260	299	(39)
Ford	240	427	(187)
Iroquois	461	486	(25)
Livingston	494	550	(56)
McLean	1,306	1,118	188
Macon	1,331	1,253	78
Moultrie	318	369	(51)
Piatt	160	160	0
Shelby	264	265	(1)
Vermilion	692	779	(87)
HEALTH SERVICE AREA 005			
Alexander/Polaski	124	83	41
Bond	172	198	(26)
Clay	133	209	(76)
Crawford	246	220	26
Edwards/Webash	175	139	36
Effingham	490	432	58
Fayette	255	261	(6)
Franklin	442	390	52
Gallatin/Hamilton/Saline	684	663	21
Hardin/Pope	95	113	(18)
Jackson	376	427	(51)
Jasper	82	82	0
Jefferson	424	346	78
Johnson/Massac	338	312	26
Lawrence	325	340	(15)
Marion	862	605	257

LONG-TERM CARE BED INVENTORY UPDATES

09/16/2011 - 05/16/2012

LONG-TERM CARE GENERAL NURSING BED NEED

PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
Perry	207	210	(3)
Randolph	580	492	88
Richland	360	309	51
Union	351	293	58
Washington	172	263	(91)
Wayne	133	169	(36)
White	354	353	1
Williamson	600	543	57
HEALTH SERVICE AREA		006	
Planning Area 6-A	5,963	7,217	(1,254)
Planning Area 6-B	4,252	4,178	74
Planning Area 6-C	5,209	5,037	172
HEALTH SERVICE AREA		007	
Planning Area 7-A	4,482	3,323	1,159
Planning Area 7-B	7,180	6,848	332
Planning Area 7-C	6,867	5,930	937
Planning Area 7-D	2,519	2,904	(385)
Planning Area 7-E	9,328	9,124	204
HEALTH SERVICE AREA		008	
Kane	3,322	2,894	428
Lake	5,275	4,699	576
McHenry	1,501	1,032	469
HEALTH SERVICE AREA		009	
Grundy	260	265	(5)
Kankakee	1,290	1,368	(78)
Kendall	219	185	34
Will	3,479	2,790	689
HEALTH SERVICE AREA		010	
Henry	452	500	(48)
Mercer	222	186	36
Rock Island	1,243	1,326	(83)
HEALTH SERVICE AREA		011	
Clinton	432	406	26
Madison	2,048	2,193	(145)
Monroe	435	324	111
St.Clair	2,102	2,294	(192)
LONG-TERM CARE ICF/DD 16 BED NEED			
PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
HSA 1	268	360	(92)
HSA 2	268	317	(49)
HSA 3	230	383	(153)
HSA 4	322	334	(12)
HSA 5	255	591	(336)
HSA 6,7,8 & 9	3,429	1,101	2,328
HSA 10	82	40	42
HSA 11	220	384	(164)



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- Local Movie Listings
- Helpful Links
- Kids Corner - Games
- Lake County Zip Codes
- For Business Owners
- GoFLO Opportunities
- Sandy's Corner



ZIP Codes in Lake County, Illinois		
ZIP Code	City	State
60001	ANTIOCH	IL
60010	BARRINGTON	IL
60011	BARRINGTON	IL
60019	DEERFIELD	IL
60020	FOX LAKE	IL
60030	GRAYSLAKE - THIRD LAKE	IL
60031	GURNEE	IL
60035	HIGHLAND PARK	IL
60037	PORT SHERIDAN	IL
60040	HIGHWOOD	IL
60041	INGLESIDE	IL
60042	ISLAND LAKE	IL
60044	LAKE BLUFF	IL
60045	LAKE FOREST	IL
60046	LAKE VILLA	IL
60047	LAKE ZURICH	IL
60048	LIBERTYVILLE	IL
60049	LONG GROVE	IL
60060	MUNDELEIN	IL
60061	VERNON HILLS	IL
60064	NORTH CHICAGO	IL
60069	LINCOLNSHIRE	IL
60073	ROUND LAKE	IL
60075	RUSSELL	IL
60079	WAUKEGAN	IL
60083	WADSWORTH	IL
60084	WAMONDA	IL
60085	WAUKEGAN	IL
60085	NORTH CHICAGO	IL
60087	WAUKEGAN	IL
60088	GREAT LAKES	IL
60089	BUFFALO GROVE	IL
60092	LIBERTYVILLE	IL
60098	WINTHROP HARBOR	IL
60099	ZION	IL

Wauconda Healthcare and Rehabilitation Centre
Admissions by Zip Code within 30-Minute Travel Time Countour

All Zip Codes within 30-Minutes			
ZIP Code	Within Lake Co.	Population: Total (2007) by ZIP Code	
60002	Out	23946	
60004	Out	50433	
60005	Out	28179	
60008	Out	22619	
60010	In	44279	
60012	Out	10921	
60013	Out	28443	
60014	Out	54428	
60015	In	28450	
60020	In	7666	
60021	Out	6451	
60030	In	36376	
60031	In	40480	
60041	In	11650	
60042	In	10167	
60044	In	12102	
60045	In	22778	
60046	In	35988	
60047	In	43948	
60048	In	32492	
60050	Out	41517	
60051	Out	14837	
60056	In	55424	
60060	In	41219	
60061	Out	24162	
60064	Out	15703	
60067	Out	36356	
60069	In	8709	
60070	Out	16408	
60071	Out	3963	
60072	Out	810	
60073	In	48245	
60074	Out	37548	
60081	Out	9315	
60084	In	15787	
60085	In	77056	
60088	In	17001	
60089	Out	46420	
60090	Out	36267	
60097	Out	11595	
60102	Out	35005	
60107	Out	36445	
60110	Out	38684	
60118	Out	20128	
60120	Out	54654	
60156	Out	34263	
60169	Out	3545	
60173	Out	11578	
60182	Out	904	
60184	Out	36027	
60185	Out	28706	

12-Month Ending	Within 30-min	Outside 30-min	Within Lake Co.
Feb-12			
32609		1	
32725		1	
46373		2	
46544		1	
53105		5	
53120		1	
53128		1	
53181		1	
60002	7		7
60010	39		39
60012	12		
60013	22		
60014	24		
60018		1	
60021	2		
60030	13		
60031	4		4
60033		1	
60037		1	
60041	12		12
60042	28		28
60046	5		5
60047	28		28
60048	2		2
60050	24		
60051	42		
60056	1		
60060	10		10
60062		3	
60068		2	
60069	2		2
60071	1		
60073	23		23
60077		1	
60081	5		
60089	83		83
60097	6		
60098		2	
60099		4	4
60102	9		
60142		2	
60156	2		
60173	1		
60189		1	
60193		4	
60453		3	
60513		1	
60548		1	
60618		1	
60630		1	
60631		2	
60706		1	
72653		1	
407	46	247	
90%	10%	55%	

12-Month Ending	Within 30-min	Outside 30-min	Within Lake Co.
Mar-11			
32725		1	
33684		1	
34108		1	
34293		2	
36303		1	
53128		1	
53179		1	
60002	1		1
60004	3		
60010	41		41
60012	7		
60013	12		
60014	21		
60020	38		38
60021	2		
60025		1	
60030	24		24
60041	17		17
60042	19		19
60046	6		6
60047	18		18
60048	4		4
60050	30		
60051	38		
60060	16		16
60067	1		
60069	3		3
60071	2		
60073	28		28
60081	13		
60084	105		105
60085	2		2
60089	1		1
60090	7		
60097	6		
60098		1	
60099		2	2
60102	5		
60107	1		
60142		9	
60156	3		
60190		1	
60191		1	
60416		2	
60456		1	
60634		1	
60706		1	
60714		3	
61008		5	
61073		1	
66084		1	
72653		1	
80097		1	
470	40	323	
92%	8%	83%	

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued VI)

Criterion 1110.230 - Project Purpose, Background and Alternatives

ALTERNATIVES

- 1) Document ALL of the alternatives to the proposed project:

Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

The alternatives to this project are, in fact, limited. The only smaller project would be to maintain the status quo or to discontinue the entire project as to do nothing that would substantially modernize Wauconda Healthcare and Rehabilitation Centre would continue to erode the marketability of this aging structure. A project of greater scope could conceivably be anything up to the State's identified need for bed of 576 additional nursing care beds with a maximum gross square footage per bed of up to 713 square feet. For this reason, the Applicant exhaustively examined the alternatives of Discontinuation and the total off-site facility replacement to include the addition of addition of 40 nursing care beds as alternatives to the proposed project.

DISCONTINUATION OF WAUCONDA REHABILITATION AND CARE CENTRE

Cost

There would be no capital cost to this alternative.

Patient Access

For Calendar Year 2011, Wauconda Healthcare and Rehabilitation Centre experienced an average daily census of 121 residents. With the optimal utilization rate of 90%, 121 residents equates to 90 percent (89.6%). Therefore, in this alternative to the proposed project, patient accessibility will not be maintained for these existing residents. Additionally, the

ATTACHMENT-13

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES -- INFORMATION REQUIREMENTS (Continued VII)

Criterion 1110.230 - Project Purpose, Background and Alternatives

ALTERNATIVES (Continued II)

discontinuation of this project would further add to the need for additional nursing beds in the Lake County Planning Area.

Quality

In discontinuing the existing services, the issue of quality is mute. The level of quality currently being provided is completely diminished by this alternative.

Financial Benefits

As with the issue of quality, the potential of financial or other benefits to this alternative are non-existent. The subject facility has been rather successful over the years as it has through the "20-bed/10 percent" rule increased its licensed capacity from 117 up to 135 in six years and with maintaining the State's optimal utilization rate of 90%. Any potential to continue such success would be eliminated by this alternative.

TOTAL OFF-SITE REPLACEMENT OF SUBJECT FACILITY TO INCLUDE THE ADDITION OF 40 NURSING BEDS TO THE EXISTING 135 BED COMPLIMENT

Cost

The capital cost of this alternative, not including land is estimated from the following assumptions: 1. The new facility square footage would more likely require the full allowable gross square footage per bed, 713GSF/bed; and, 2. The new construction cost per square foot would also be on the higher end of the range, estimated to be around \$220 per gross square foot. Together with the total bed complement of 175 nursing care beds, the new structure would contain approximately 124,775 gross square feet and costing some \$27,450,500 for only the construction plus contingency cost or hard cost. This alternative does not attempt to estimate the

ATTACHMENT-13

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued VIII)

Criterion 1110.230 - Project Purpose, Background and Alternatives

ALTERNATIVES (Continued III)

total soft costs associated with the “from scratch” development of a new long-term care nursing care facility.

Patient Access

In this alternative, resultant patient accessibility is maintained to the level of the proposed project.

Quality

This proposed alternative would not result in a new operational philosophy as the ownership and operations would remain the same. Additionally, the project would be utilizing the existing staff in-place. Therefore, quality of care provided is to be maintained and is not an issue as compared to the project as being proposed.

Financial Benefits

The potential of financial or other benefits to this alternative will require a longer time to materialize. The most obvious benefit would be that the entire building would be seamless as opposed to trying to make the proposed new construction areas appear similar to the existing building. An entire new building at the top end of the allowable cost and size could also be considered a benefit but somebody has to pay for it also. This Applicant would have to go from an all cash/internal funds method of funding the project to a more expensive debt financing funding method. This higher cost could require this Applicant to alter its existing payor mix which is 73 percent Medicaid, 18 percent Medicare and 9 percent private pay or other sources of funds to a mix that may provide a higher return, i.e., a larger Medicare and or Private pay clientele.

ATTACHMENT-13

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES – INFORMATION REQUIREMENTS (Continued IV)

Criterion 1110.230 - Project Purpose, Background and Alternatives

ALTERNATIVES (Continued IV)

Neither alternative to the project as being proposed provides to best outcome in-terms of sustainability and affordability. The project as being proposed has construction and contingency costs of around \$8 million dollars compared to one of over \$27 million for the total replacement project or a zero or negative return should the facility ultimately go under. Existing quality is maintained and patient accessibility is not only maintained but it is also improved in the best economical light as the entire State and Country seem to be struggling financially. It seems that the most advantageous alternative is to utilize the existing health care resources, update them and expand as appropriate in a limited and responsible fashion. Thus the alternative of the project as being proposed was selected.

- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

This alternative is not based solely or in part on improved quality of care except in how the improved physical plant will provide a more modern and efficient physical environment. Therefore, this item appears to be not germane.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

This project proposes the following:

Existing as is (not renovated space): 32,876gsf

Existing (to be renovated): 6,023gsf

Total Existing: 38,899gsf

New Construction: 41,979gsf

Total Upon Project Completion: 80,878gsf / 175beds =462 gross square feet per bed.

The current State Standard allows for a range of up to 713 gross square feet per bed. As such, it appears that the proposed project's physical space is in compliance with this criterion.

2. If the gross square footage exceeds the GSF standards in Appendix B, justify the discrepancy by documenting one of the following:

- a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

As noted above, the proposed project's size per square foot is within the limit for gross square feet per bed per the State's standards. Therefore, this item is not germane.

- b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

The proposed project's size per square foot within the limit for gross square feet per bed as per the State's standards; therefore, this item is not germane.

- c. The project involves the conversion of existing bed space that results in excess square footage.

The project does not involve the conversion of existing bed space; therefore, this item is not germane.

ATTACHMENT-14

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE
(CONTINUED II)**

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

PROJECT SERVICES UTILIZATION:

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

The HFSRB has established utilization standards for General Long-Term Nursing Care facilities of 90% by the second full year of operation. The Applicant's ability to reach and maintain this target is supported by its historical and ongoing demand and the local hospital's anticipation to continue making referrals to the subject facility. Appended as **ATTACHMENT-15A** is a letter of support from Advocate Good Shepherd Hospital stating that they "anticipate that our referral relationship will continue in a similar volume as in the past years". While referrals are essential, the Applicant also has the advantage of current operations and historical demand. This will be the third expansion of licensed capacity since CY 2005. In CY 2005, Wauconda Healthcare and Rehabilitation Centre had a licensed capacity of 117 nursing care beds. In CY 2006, the facility's IDPH profile (annual questionnaire data) reported that the facility had increased its licensed capacity to 125, an increase of eight beds. Again in CY 2009, the Facility's IDPH profile (annual questionnaire data) reported an increase of ten beds to bring the licensed capacity up to its current level of 135 nursing beds. With each increase this Applicant was able to reach and maintain the State's optimal utilization rate of 90%. Now, the Applicant has found that in maximizing the existing capacity in the ever evolving long-term care industry has found the facility in need of updates and modernization of its ancillary and support areas as well as providing more private room accommodations to maintain marketability and, more importantly, to provide the most current amenities that this elderly population demands.

ATTACHMENT-15

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE
(CONTINUED III)**

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

PROJECT SERVICES UTILIZATION (Continued ii):

Therefore, reaching and maintaining the optimal utilization rate of 90% should not be an issue for this Applicant in this facility.

Advocate Good Shepherd Hospital

450 West Highway 22 || Barrington, IL 60010 || T 847.381.0123 || advocatehealth.com

May 18, 2012

Ms. Kimberly Clawson
Lancaster Health Group
5061 N. Pulaski Road
Suite 203
Chicago, IL. 60630

Dear Ms. Clawson,

On behalf of Advocate Good Shepherd Hospital I am writing this letter in support of Wauconda Health Care's new addition to their skilled nursing facility. Wauconda Health Care is one of our skilled nursing facility partners who routinely serve persons who are discharged from our hospital. Based on the historical relationship between Advocate Good Shepherd and Wauconda health Care we anticipate that our referral relationship will continue in a similar volume as in the past years.

Sincerely,



Julie Mayer
Director, Community & Government Relations

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

PLEASE NOTE: The criteria for long-term care under this section has been repealed and replaced with criteria 1125. Since the new criteria does not have a application process, the Applicant is utilizing the 1110 and 1120 application form that has been in place and substituting the 1110.1700 criteria with the 1125 criteria and many sections have already been addressed in the existing application.

GENERAL LONG-TERM CARE

Criterion 1125.510 – Introduction

- Applicants proposing to establish, expand and/or modernize General Long Term Care must submit the following information:

Indicate bed capacity changes by Service:

Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
<input checked="" type="checkbox"/> General Long Term Care	135	175	0	+40	17

- READ THE APPLICABLE REVIEW CRITERIA OUTLINED BELOW and submit the required documentation for the criteria:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
	Section	Subject
Expansion of Existing Services	.520	Background of the Applicant
	.530(b)	Service to Planning Area Residents
	.550(a) + (b) or (c)	Service Demand – Expansion of General Long-Term Care
	.590	Staffing Availability
	.600	Bed Capacity
	.620	Project Size
	.640	Assurances
	.560(a)(1) through (3)	Continuum of Care Components
	.590	Staffing Availability
	.600	Bed Capacity
	.810	Community Related Functions
	.630	Zoning
	.640	Assurances
Modernization	.650(a)	Deteriorated Facilities
	.650(b) & (c)	Documentation
	.650(d)	Utilization
	.600	Bed Capacity
	.810	Community Related Functions
	.620	Project Size
	.630	Zoning

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED II)

Criterion 1125.520 -- Background of the Applicant

BACKGROUND OF APPLICANT

Please find this section addressed under Section III, Part 1110.230.a), as this application form follows sections 1110 and 1120 and not the revised rules for long-term care under the new section 1125.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED III)

Criterion 1125.530 - Planning Area Need

- A. Identify the calculated number of beds needed (excess) in the planning area.

In accordance with the applicable review criteria outlined above in this section, this item is not germane as this project is for the expansion of existing services. That being said, the State's calculated bed need shows an outstanding need for 576 additional long-term care nursing beds. Please refer to **ATTACHMENT LTC-17A** for a copy of the State's Inventory of Health Care Facilities and Services and Need Determinations and its May 16, 2012 Update to the Inventory.

- B. Attest that the primary purpose of the project is to serve residents of the planning area and that at least 50% of the patients will come from within the planning area.

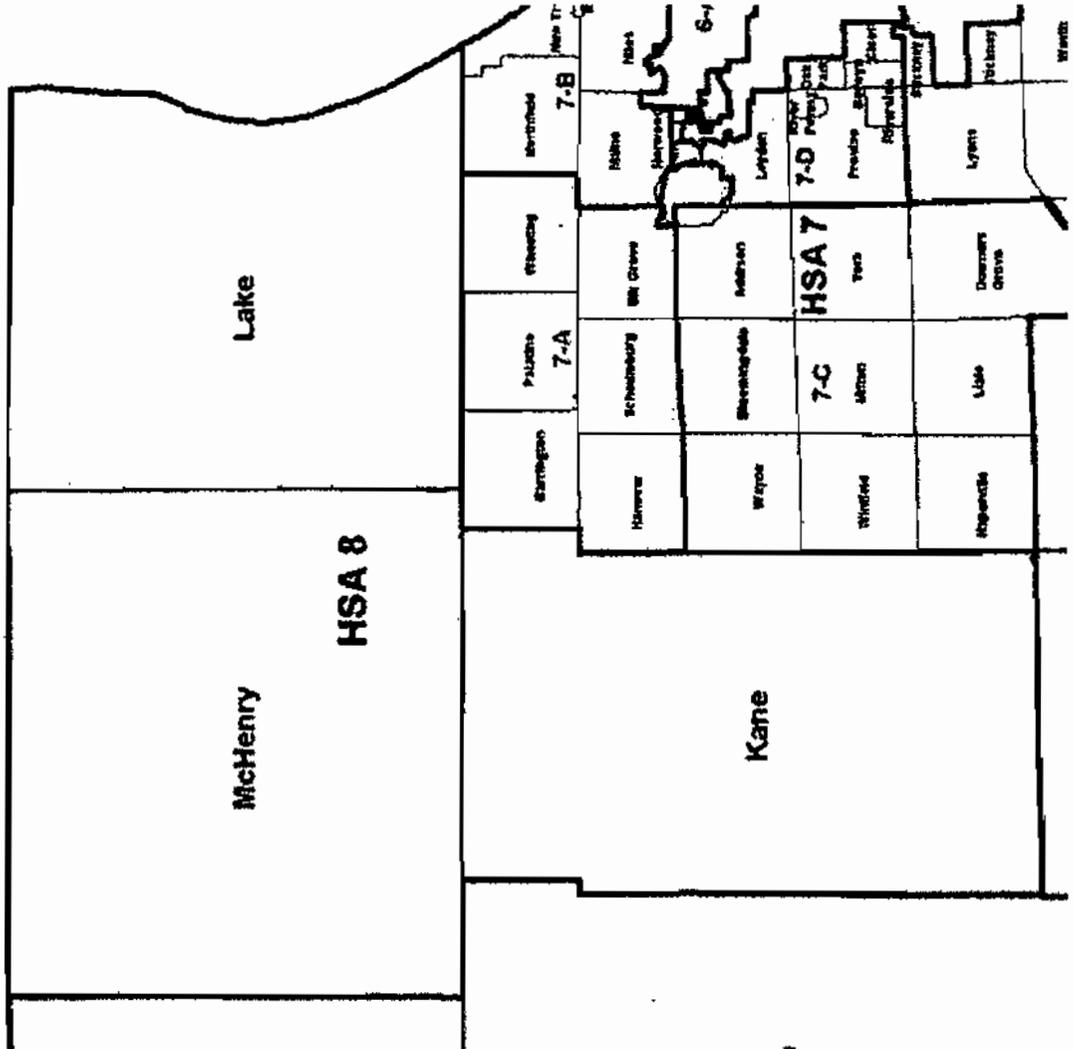
The primary planning area is the Lake County Planning Area within HSA VIII. The Applicant's campus residents' patient origin data shows 510 residents on campus with 323 residents (63%) originating from within Lake County. More impressive is that 470 or 92 percent of the total residents originate from within the 30-minute travel time contour of the existing site. Please refer to the Applicant's documentation appended as **ATTACHMENT LTC-17B** for the patient origin data.

ATTACHMENT LTC-17

INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS

Illinois Department of Public Health
Illinois Health Facilities and Services Review Board

Health Service Area 8



INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS

Illinois Department of Public Health
 Illinois Health Facilities and Services Review Board

14-Oct-11
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Summary of General Long-Term Nursing Care Beds and Need by Planning Area				
Health Service Area 8				
PLANNING AREA	EXISTING BEDS	PROJECTED BEDS NEEDED - 2018	ADDITIONAL BEDS NEEDED	EXCESS BEDS
Kane County	2993	3322	329	0
Lake County	4825	5275	450	0
McHenry County	1032	1501	469	0
HSA 8 TOTALS	8850	10098	1248	0

INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS

Illinois Department of Public Health
 Illinois Health Facilities and Services Review Board

General Long-Term Care Category of Service

25-Jul-11
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Planning Area: Lake			General Nursing Care	
Facility Name	City	County/Area	Beds	2008 Patient Days
ABBOTT HOUSE	HIGHLAND PARK	Lake County	106	37,926
ALDEN-LONG GROVE REHAB/HC CENTER	LONG GROVE	Lake County	248	59,908
ARLINGTON REHAB & LIVING CENTER	LONG GROVE	Lake County	190	64,656
BAYSIDE TERRACE	WAUKEGAN	Lake County	168	53,065
BRENTWOOD-NORTH HEALTHCARE & REHAB CEN	RIVERWOODS	Lake County	240	45,920
9/1/2008 Name Change Name changed from Brentwood-North Nursing Center.				
CLAREMONT REHAB & LIVING CTR.	BUFFALO GROVE	Lake County	200	58,561
CLARIDGE HEALTHCARE CENTER	LAKE BLUFF	Lake County	231	37,001
GLEN LAKE TERRACE NURSING & REHAB	WAUKEGAN	Lake County	271	80,098
HELIA HEALTHCARE OF ZION	ZION	Lake County	116	29,160
4/8/2009 Name Change Name changed from Arbor View Nursing & Rehab Center.				
4/8/2009 Own. Change Change of ownership occurred.				
HIGHLAND PARK NURSING & REHAB	HIGHWOOD	Lake County	104	27,061
9/20/2010 Bed Change Added 9 general nursing care beds; facility now authorized for 104 general nursing care beds.				
HILLCREST RETIREMENT VILLAGE	RND LAKE BEACH	Lake County	142	46,817
LAKE FOREST HOSPITAL	LAKE FOREST	Lake County	88	24,881
LAKE FOREST PLACE	LAKE FOREST	Lake County	63	20,638
LAKE PARK CENTER	WAUKEGAN	Lake County	210	74,496
LEXINGTON OF LAKE ZURICH	LAKE ZURICH	Lake County	203	64,289
9/2/2009 Bed Change Discontinued 11 Nursing Care beds. Facility now has 198 Nursing Care beds.				
12/21/2010 Bed Change Added 5 Nursing Care beds; facility now has 203 Nursing Care beds.				
LIBERTYVILLE MANOR EXTENDED CARE	LIBERTYVILLE	Lake County	174	21,769
MANOR CARE OF HIGHLAND PARK	HIGHLAND PARK	Lake County	215	32,570
MANOR CARE OF LIBERTYVILLE	LIBERTYVILLE	Lake County	150	43,745
10/31/2008 Name Change Name changed from Manor Care - Libertyville.				
PAVILION OF WAUKEGAN	WAUKEGAN	Lake County	109	31,069
PRAIRIEVIEW AT THE GARLANDS	BARRINGTON	Lake County	20	4,738
ROLLING HILLS MANOR NURSING HOME	ZION	Lake County	127	40,394
SEDGEBROOK HEALTH CENTER	LINCOLNSHIRE	Lake County	44	
6/15/2009 05-036 Licensed 44 nursing care beds permitted under project 05-036; additional 44 nursing beds remain unfinished.				
6/15/2009 Name Change Name changed from Sedgebrook Retirement Community.				
5/24/2010 05-036 Permit declared null and void; 44 beds under development removed from inventory.				
11/19/2010 CHOW Change of ownership occurred.				
11/19/2010 Name Change Name changed from Renaissance Gardens Sedgebrook.				
SEDGEBROOK HEALTH CENTER (PERMIT)	LINCOLNSHIRE	Lake County	44	
7/21/2011 11-009 Received permit to add 44 Nursing Care beds to existing facility.				
SHELTERING OAK	ISLAND LAKE	Lake County	70	23,486

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ATTACHMENT LTC-17A

INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS

Illinois Department of Public Health
Illinois Health Facilities and Services Review Board

General Long-Term Care Category of Service

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Planning Area: Lake

Facility Name	City	County/Area	General Nursing Care	
			Beds	2008 Patient Days
SHERIDAN HEALTH CARE CENTER	ZION	Lake County	230	71,054
7/1/2010 Bed Change Discontinued 20 Nursing Care beds; facility now has 230 Nursing Care beds.				
THE TERRACE NURSING HOME	WAUKEGAN	Lake County	115	40,239
THE VILLAGE AT VICTORY LAKES	LINDENHURST	Lake County	120	33,445
THE WEALSHIRE	LINCOLNSHIRE	Lake County	142	43,099
WAUCONDA HEALTHCARE & REHAB	WAUCONDA	Lake County	135	39,873
12/29/2009 Bed Change Added 10 nursing care beds; facility now has 135 nursing care beds.				
WHITEHALL- NORTH	DEERFIELD	Lake County	190	56,666
WINCHESTER HOUSE NURSING HOME	LIBERTYVILLE	Lake County	360	82,923
Planning Area Totals			4,825	1,289,547

HEALTH SERVICE AREA	AGE GROUPS	2008 Patient Days	2008 Population	2008 Use Rates (Per 1,000)	2008 Minimum Use Rates	2008 Maximum Use Rates
008	0-64 Years Old	530,813	1,423,200	373.0	223.8	596.8
	65-74 Years Old	291,725	70,900	4,114.6	2,468.8	6,583.4
	75+ Years Old	1,525,347	58,700	25,985.5	15,591.3	41,576.7

	2008 PSA Patient Days	2008 PSA Estimated Populations	2008 PSA Use Rates (Per 1,000)	2008 HSA Minimum Use Rates	2008 HSA Maximum Use Rates	2018 PSA Planned Use Rates	2018 PSA Projected Populations	2018 PSA Planned Patient Days	Planned Average Daily Census	Planned Bed Need (90% Occ.)	Beds Needed
0-64 Years Old	327,807	653,000	502.0	223.8	596.8	502.0	713,400	358,128			
65-74 Years Old	171,821	35,700	4,807.3	2,468.8	6,583.4	4,807.3	57,000	274,017			
75+ Years Old	790,119	28,500	27,723.5	15,591.3	41,576.7	27,723.5	39,700	1,100,622			
Planning Area Totals								1,732,767	4,747.3	5,275	450

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LONG TERM CARE FACILITY UPDATES
9/16/2011 - 6/16/2012
CHANGES TO GENERAL LONG-TERM CARE

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION
Planning Area 7-A	05-002	12/6/2011	Assisi Healthcare Center At Clare Oaks, Bartlett	Permit renewal through June 30, 2012.
	Bed Change	3/16/2012	St. Joseph'S Home For Elderly, Palatine	Discontinued 1 Nursing Care bed; facility now has 59 Nursing Care and 7 Sheltered Care beds.
Planning Area 7-B	Closure	10/17/2011	Holy Family Nursing & Rehab Ctr., Des Plaines	Facility closed effective October 17, 2011; 251 Nursing Care beds removed from inventory.
Planning Area 7-C	11-055	10/13/2011	Transitional Care Center Of Naperville, Naperville	Permit issued to establish a 120 bed Nursing care facility at Arbiter Court and East Diehl Road in Naperville.
	Bed Change	10/13/2011	Beacon Hill, Lombard	Added 2 nursing care beds; facility now has 110 nursing care beds.
	CHOW	1/3/2012	Burgess Square, Westmont	Change of ownership occurred.
	Bed Change	2/9/2012	Dupage Convalescent Home, Wheaton	Discontinued 140 Nursing Care beds. Facility now has 368 Nursing Care beds.
	12-006	4/17/2012	Elmhurst Memorial Hospital, Elmhurst	Permit issued to discontinue 38 bed Skilled Care (Long-Term Care) category of service.
	07-071	4/17/2012	Park Place Christian Village, Elmhurst	Permit abandoned.
	Name Change	4/17/2012	Park Place Christian Village, Elmhurst	Formerly Park Place Christian Community.
	12-007	4/17/2012	Park Place Christian Village, Elmhurst	Permit issued to establish a facility with 37 Nursing Care beds.
	07-042	6/1/5400	Marianjoy Rehab Hospital Wheaton	Completed project to establish 20 bed skilled nursing (long-term care) category of service.
	Planning Area 7-D	Name Change	1/3/2012	Oakridge Healthcare Center, Hillside
CHOW		1/3/2012	Oakridge Healthcare Center, Hillside	Change of ownership occurred.
Planning Area 7-E	Correction	1/6/2012	Pershing Gardens Healthcare Center, Stickney	City location corrected from Berwyn to Stickney.
	Correction	1/6/2012	Pershing Gardens Healthcare Center, Stickney	Record corrected to indicate facility location in Stickney, not Berwyn as previously indicated.
	CHOW	1/6/2012	Pershing Gardens Healthcare Center, Stickney	Change of ownership occurred.
	Name Change	1/6/2012	Pershing Gardens Healthcare Center, Stickney	Name changed from Pershing Convalescent Center.
	CHOW	1/13/2012	Crestwood Care Centre, Crestwood	Change of Ownership occurred.
	Bed Change	2/29/2012	Manorcare Of South Holland, South Holland	Added 16 Nursing Care beds to existing facility; facility now has 216 Nursing Care beds.
	11-104	4/17/2012	Mcalister Nursing & Rehab(Permit), Tinley Park	Permit issued to add 89 Nursing Care beds to existing facility; facility now authorized for 200 beds.
	12-003	4/17/2012	Holy Family Villa(Permit), Palos Park	Permit issued to add 30 Nursing Care beds to existing facility; facility now authorized for 129 beds.
Bed Change	5/17/2012	Manorcare Of Homewood, Homewood	Added 12 Nursing Care beds to existing facility; facility now has 132 Nursing Care beds.	
Health Service Area B				
Kane	Name Change	10/1/2011	Heritage Health - Elgin, Elgin	Formerly Heritage Manor - Elgin.
	Closure	10/13/2011	Fox River Pavilion, Aurora	Facility deemed closed; 99 Nursing care beds removed from inventory by Board order.
	09-030	12/6/2011	Addison Rehabilitation & Living Center (Permit), Elgin	Permit renewal granted through December 31, 2014.
Lake	CHOW	1/10/2012	Countryside Care Center, Aurora	Change of Ownership occurred.
	Bed Change	10/1/2011	Rolling Hills Manor Nursing Home, Zion	Discontinued 12 Nursing care beds; facility now has 115 nursing care beds.
	Closure	10/13/2011	Heita Healthcare Of Zion, Zion	Facility deemed closed; 116 Nursing care beds removed from inventory by Board order.
	Bed Change	11/4/2011	Hillcrest Retirement Village, Rnd Lake Beach	Added 2 Nursing care beds; facility now has 144 Nursing care beds.
11-009	11/29/2011	Radford Green, Lincolnshire	Project completed to add 44 Nursing Care beds; facility now has 88 Nursing Care beds.	

LONG TERM CARE FACILITY UPDATES
9/16/2011 - 6/16/2012
CHANGES TO GENERAL LONG-TERM CARE

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION	
	11/6/2009	Bed Change	The Weaishire, Lincolnshire	Facility added 2 Nursing Care beds and discontinued 2 Sheltered Care beds. Facility now has 144 Nursing Care beds and 0 Sheltered Care beds.	New
McHenry	CHOW	1/1/2012	Woodstock Residence, Woodstock	Change of ownership occurred.	New
	Name Change	6/1/2012	Crossroads Care Center Woodstock, Woodstock	Name changed from Woodstock Residence.	New
Health Service Area 9					
Will	10-005	11/17/2011	Smith Crossing, Orland Park	Facility licensed 16 Nursing Care beds under permit 10-005; facility now has a total of 46 Nursing Care beds.	
	Bed Change	12/7/2011	Sunny Hill Nursing Home Will County, Joliet	Facility discontinued 20 Nursing Care beds; facility now has 280 Nursing Care beds.	
	CHOW	1/10/2012	Deerbrook Care Centre, Joliet	Change of Ownership occurred.	
	07-302	3/9/2012	Alden Estates Of Shorewood, Shorewood	Facility licensed for operation with 100 Nursing Care beds.	
Health Service Area 10					
Henry	Bed Change	7/12/2011	Hammond-Henry District Hospital, Geneseo		
Health Service Area 11					
Madison	Bed Change	10/28/2011	St. Clare'S Hospital, Alton	Facility discontinued 4 Nursing Care beds; facility now has 26 Nursing Care beds.	
	Bed Change	1/17/2012	Collinsville Rehab & Health Care Ctr., Collinsville	Facility discontinued 2 Nursing Care beds; facility now has 98 Nursing Care beds.	
CHANGES TO SPECIALIZED LONG-TERM CARE					
Health Service Area 2					
LaSalle	Closure	3/28/2012	Knox Estates, Streator	Facility ceased operations; 16 ICF/DD beds removed from inventory.	
Health Service Area 5					
Edwards/Wabash	Closure	4/1/2012	River Oaks, Mount Carmel	Facility ceased operations; 16 ICF/DD beds removed from inventory.	
Gallatin/Hamilton/Saline	Closure	5/1/2012	Brooke Hill, Eldorado	Facility ceased operation; 16 ICF/DD beds removed from inventory.	
Lawrence	Closure	10/17/2011	Hickory Estates, Sumner	Facility closed; 16 ICF/DD beds removed from inventory.	
Union	Closure	12/28/2011	Village Inn - Cobden, Cobden	Facility closed 12/28/2011; 16 ICF/DD beds removed from inventory.	
	Closure	4/2/2012	Holly Hill, Anna	Facility ceased operations; 16 ICF/DD beds removed from inventory.	
Williamson	Closure	10/13/2011	Independence Place, Herrin	Facility deemed closed; 16 ICF/DD Adult beds removed from inventory by Board order.	
Health Service Area 6, 7, 8, 9					
Kankakee	Closure	3/31/2012	Gravlin Square, Bradley	Facility ceased operations; 16 ICF/DD beds removed from inventory.	
Planning Area 7-D	CHOW	3/1/2012	Bellwood Nursing Center, Bellwood	Change of Ownership occurred.	
	Name Change	3/2/2012	Bellwood Nursing Center, Bellwood	Formerly Aspire on Eastern.	
Planning Area 7-E	Closure	4/10/2012	Bethshan II, Palos Heights	Facility ceased operation; 16 ICF/DD beds removed from inventory.	

LONG TERM CARE FACILITY UPDATES

9/16/2011 - 6/16/2012

CALCULATED BED NEEDS

Planning Area	Calculated Beds Needed	Approved Beds	Additional Beds Needed or Excess Beds ()
HEALTH SERVICE AREA 5			
Alexander/Pulaski	124	83	41
Bond	172	198	(26)
Clay	133	209	(76)
Crawford	246	220	26
Edwards/Wabash	175	139	36
Effingham	490	432	58
Fayette	255	261	(6)
Franklin	442	390	52
Gallatin/Hamilton/Saline	684	590	94
Hardin/Pope	95	113	(18)
Jackson	376	427	(51)
Jasper	82	82	0
Jefferson	424	346	78
Johnson/Massac	338	312	26
Lawrence	325	340	(15)
Marion	862	605	257
Perry	207	210	(3)
Randolph	580	492	88
Richland	360	309	51
Union	351	293	58
Washington	172	263	(91)
Wayne	133	169	(36)
White	354	353	1
Williamson	600	543	57
HEALTH SERVICE AREA 6			
Planning Area 6-A	5963	7217	(1254)
Planning Area 6-B	4252	4178	74
Planning Area 6-C	5209	5037	172
HEALTH SERVICE AREA 7			
Planning Area 7-A	4482	3323	1159
Planning Area 7-B	7180	6848	332
Planning Area 7-C	6867	5930	937
Planning Area 7-D	2519	2904	(385)
Planning Area 7-E	9328	9136	192
HEALTH SERVICE AREA 8			
Kane	3322	2894	428
Lake	5275	4701	574
McHenry	1501	1032	469
HEALTH SERVICE AREA 9			
Grundy	260	265	(5)
Kankakee	1290	1368	(78)
Kendall	219	185	34
Will	3479	2790	689
HEALTH SERVICE AREA 10			
Henry	452	500	(48)
Mercer	222	186	36
Rock Island	1243	1326	(83)
HEALTH SERVICE AREA 11			
Clinton	432	406	26
Madison	2048	2193	(145)
Monroe	435	324	111
St. Clair	2102	2294	(192)

Wauconda Healthcare and Rehabilitation Centre
Admissions by Zip Code within 30-Minute Travel Time Countour

All Zip Codes within 30-Minutes

ZIP Code	Within Lake Co.	Population: Total (2007) by ZIP Code
60002	Out	23946
60004	Out	50433
60005	Out	28179
60008	Out	22819
60010	In	44279
60012	Out	10921
60013	Out	28443
60014	Out	54428
60015	In	28450
60020	In	7686
60021	Out	6451
60030	In	36376
60031	In	40480
60041	In	11650
60042	In	10187
60044	In	12102
60045	In	22778
60046	In	35988
60047	In	43948
60048	In	32492
60050	Out	41517
60051	Out	14837
60056	In	55424
60080	In	41219
60061	Out	24162
60064	Out	15703
60067	Out	36356
60069	In	8709
60070	Out	16408
60071	Out	3983
60072	Out	810
60073	In	48245
60074	Out	37548
60081	Out	9315
60084	In	15787
60085	In	77056
60088	In	17001
60089	Out	46420
60090	Out	36267
60097	Out	11595
60102	Out	35005
60107	Out	36445
60110	Out	38684
60118	Out	20128
60120	Out	54654
60156	Out	34263
60169	Out	3545
60173	Out	11578
60192	Out	804
60194	Out	36027
60195	Out	28706

12-Month Ending Feb-12	Within 30-min	Outside 30-min	Within Lake Co.
32609		1	
32725		1	
46373		2	
46544		1	
53105		5	
53120		1	
53128		1	
53181		1	
60002	7		7
60010	39		39
60012	12		
60013	22		
60014	24		
60018		1	
60021	2		
60030	13		
60031	4		4
60033		1	
60037		1	
60041	12		12
60042	28		28
60046	5		5
60047	28		28
60048	2		2
60050	24		
60051	42		
60056	1		
60060	10		10
60062		3	
60068		2	
60069	2		2
60071	1		
60073	23		23
60077		1	
60081	5		
60089	83		83
60097	6		
60098		2	
60099		4	4
60102	9		
60142		2	
60156	2		
60173	1		
60189		1	
60193		4	
60453		3	
60513		1	
60548		1	
60618		1	
60630		1	
60631		2	
60706		1	
72653		1	
	407	46	247
	90%	10%	55%

12-Month Ending Mar-11	Within 30-min	Outside 30-min	Within Lake Co.
32725		1	
33884		1	
34108		1	
34293		2	
36303		1	
53128		1	
53179		1	
60002	1		1
60004	3		
60010	41		41
60012	7		
60013	12		
60014	21		
60020	38		38
60021	2		
60025		1	
60030	24		24
60041	17		17
60042	19		19
60046	6		6
60047	16		16
60048	4		4
60050	30		
60051	36		
60060	16		16
60067	1		
60069	3		3
60071	2		
60073	28		28
60081	13		
60084	105		105
60085	2		2
60089	1		1
60090	7		
60097	6		
60098		1	
60099		2	2
60102	5		
60107	1		
60142		9	
60156	3		
60190		1	
60191		1	
60416		2	
60456		1	
60634		1	
60706		1	
60714		3	
61008		5	
61073		1	
66084		1	
72653		1	
80097		1	
	470	40	323
	92%	8%	63%

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED IV)

Criterion 1125.550 - Service Demand – Expansion of General Long-Term Care

The applicant shall document #1 and either #2 or #3:

1. Historical Service Demand

- a) An average annual occupancy rate that has equaled or exceeded occupancy standards for general LTC, as specified in Section 1125.210(c), for each of the latest two years.
- b) If prospective residents have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including completed applications that could not be accepted due to lack of the subject service and documentation from referral sources, with identification of those patients by initials and date.

The HFSRB has established utilization standards for General Long-Term Nursing Care facilities of 90% by the second full year of operation. It should be known that the Applicant, has a cumulative utilization rate of 90 percent since CY 2005 as far back as the IDPH Annual Questionnaire forms are provided on the Board's website. Specifically, refer to the Chart for the annual utilization rate that illustrates how this facility currently meets occupancy target of 90%. Copies of the facility's profiles for the respective years are appended as

Wauconda			
Calendar Year	Licensed Beds	Patient Days	Occup. %
2010	135	43,871	89%
2009	135	40,673	83%
2008	125	39,873	87%
2007	125	41,382	91%
2006	125	42,975	94%
2005	<u>117</u>	<u>40,238</u>	<u>94%</u>
Ave:	127	249,012	90%

ATTACHMENT LTC-19A. Therefore, maintaining the optimal utilization of 90% should not be an issue.

2) Projected Referrals The applicant shall provide documentation as described in Section 1125.540(d).

d) Projected Referrals

An applicant proposing to establish a category of service or establish a new LTC facility shall submit the following:

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED V)

Criterion 1125.550 - Service Demand – Expansion of General Long-Term Care (Continued ii)

- 1) Letters from referral sources (hospitals, physicians, social services and others) that attest to total number of prospective residents (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application. Referral sources shall verify their projections and the methodology used;
- 2) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources' documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed
- 3) The historical percentage of applicant market share, within a 24-month period after project completion;
- 4) Each referral letter shall contain the referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and
- 5) Verification by the referral sources that the prospective resident referrals have not been used to support another pending or approved Certificate of Need (CON) application for the subject services.

Appended as **ATTACHMENT LTC-19B**, is a letter from Advocate Good Shepherd Hospital's, Director of Community and Government Relations, Ms. Julie Mayer stating its support for the project and providing anticipation to continue referrals similar to those historically made. It should be known that the information obtained was the best available as explained to the Applicant due to the vast and detailed nature of the requested information and to availability of Hospital resources.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED VI)

Criterion 1125.550 - Service Demand – Expansion of General Long-Term Care (Continued III)

- 3) If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as described in Section 1125.540 (e).

The projected service demand is not based upon the rapid population growth; therefore, this item is not germane.

ELDERLY LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WAUWATONIA HEALTHCARE CENTER WAUWATONIA

WAUWATONIA HEALTHCARE CENTER
175 THOMAS COURT
WAUWATONIA, IL 60084

Reference Numbers Facility ID 0008425
Health Service Area 008 Planning Services Area 087

Administrative Margaret Ryan
Contact Person and Telephone Date Completed 2/24/2011
MARGARET RYAN 847-930-6561

Regulation Agent Information Under 65 Years Old
Christopher Vance
501 N. Paulina
Chicago, IL 60601

FACILITY OWNERSHIP
LIMITED LIABILITY CO

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	DIAGNOSIS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggravated/Abused Spouse	Necropsies	7
Chronic Alcoholism	Encephalopathy	11
Developmentally Disabled	Blood Disorders	3
Drug Addiction	Various System Non Achiever	17
Medicaid Recipient	Alzheimer Disease	17
Mental Illness	Mental Illness	0
Non-Aboluntary	Developmental Disability	0
Non-Alcohol	Chronic System	40
Public Aid Recipients	Respiratory System	5
Under 65 Years Old	Digestive System	0
Unable to Self-Maintain	Genitourinary System Disorders	7
Violator Demented	Skin Disorders	0
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	5
Other Restrictions	Injury and Poisonings	6
No Restrictions	Other Medical Conditions	4
	Non-Medical Conditions	4
	TOTALS	123

Note: Reported restrictions derived by ?

Total Residents Discharged as Monthly 18

ADMISSIONS AND DISCHARGES - 2010

RESIDENTS IN USE, MEDICAID/MEDICARE CENTERED BEDS	PEAK	RESIDENTS ON 1/1/2010
LICENSED BEDS	135	117
AVAILABLE BEDS	135	271
BEDS IN USE	135	283
BEDS SET-UP	135	125
BEDS USED	135	125
PEAK	135	0
LEVEL OF CARE		
Nursing Care	0	0
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTAL BEDS	135	135

FACILITY UTILIZATION - 2010

BY LEVEL OF CARE PROVIDED AND PAYOR SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Charity	Private Pay	Set Up	Peak Beds
Nursing Care	18.1%	21178	73.4%	87	12716	0	43871	88.0%
Skilled Under 22	0.0%	0	0.0%	0	0	0	0	0.0%
Intermediate DD	0.0%	0	0.0%	0	0	0	0	0.0%
Skilled Care	0.0%	0	0.0%	0	0	0	0	0.0%
TOTALS	18.1%	21178	73.4%	87	12716	0	43871	88.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		INTERMED. DD		SHELTERED		GRAND TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0
45 to 64	1	1	0	0	0	0	1	1
65 to 84	2	3	0	0	0	0	2	3
85 to 94	4	6	0	0	0	0	4	6
75 to 84	14	22	0	0	0	0	14	22
85+	11	81	0	0	0	0	11	81
TOTALS	32	93	0	0	0	0	32	93

ELDERLY LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WAUWATONIA HEALTHCARE CENTER WAUWATONIA

WAUWATONIA HEALTHCARE CENTER
175 THOMAS COURT
WAUWATONIA, IL 60084

Reference Numbers Facility ID 0008425
Health Service Area 008 Planning Services Area 087

Administrative Margaret Ryan
Contact Person and Telephone Date Completed 2/24/2011
MARGARET RYAN 847-930-6561

Regulation Agent Information Under 65 Years Old
Christopher Vance
501 N. Paulina
Chicago, IL 60601

FACILITY OWNERSHIP
LIMITED LIABILITY CO

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	DIAGNOSIS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggravated/Abused Spouse	Necropsies	7
Chronic Alcoholism	Encephalopathy	11
Developmentally Disabled	Blood Disorders	3
Drug Addiction	Various System Non Achiever	17
Medicaid Recipient	Alzheimer Disease	17
Mental Illness	Mental Illness	0
Non-Aboluntary	Developmental Disability	0
Non-Alcohol	Chronic System	40
Public Aid Recipients	Respiratory System	5
Under 65 Years Old	Digestive System	0
Unable to Self-Maintain	Genitourinary System Disorders	7
Violator Demented	Skin Disorders	0
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	5
Other Restrictions	Injury and Poisonings	6
No Restrictions	Other Medical Conditions	4
	Non-Medical Conditions	4
	TOTALS	123

Note: Reported restrictions derived by ?

Total Residents Discharged as Monthly 18

ADMISSIONS AND DISCHARGES - 2010

RESIDENTS IN USE, MEDICAID/MEDICARE CENTERED BEDS	PEAK	RESIDENTS ON 1/1/2010
LICENSED BEDS	135	117
AVAILABLE BEDS	135	271
BEDS IN USE	135	283
BEDS SET-UP	135	125
BEDS USED	135	125
PEAK	135	0
LEVEL OF CARE		
Nursing Care	0	0
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTAL BEDS	135	135

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Number	SubMed22	ICFIDD	Skilled	Swkbrkr	Total
Asian	1	0	0	0	0	1
Asian, Indian	0	0	0	0	0	0
Black	0	0	0	0	0	0
Neurology/Psyc. Is.	0	0	0	0	0	0
White	124	0	0	0	0	124
Race Unknown	0	0	0	0	0	0
Total	125	0	0	0	0	125

ETHNICITY

ETHNICITY	Number	SubMed22	ICFIDD	Skilled	Swkbrkr	Total
Hispanic	0	0	0	0	0	0
Non-Hispanic	125	0	0	0	0	125
Ethnicity Unknown	0	0	0	0	0	0
Total	125	0	0	0	0	125

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Charity
42.0%	28.0%	0.1%	28.8%	0.0%
4,542,071	3,031,048	16,070	334,183	2,897,833
TOTALS	10,822,583	0	0	0

*Charity Expense does not include expenses which may be considered a community benefit.

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	1.00
Director of Nursing	1.00
Registered Nurses	20.00
LPN's	5.00
Certified Aides	72.00
Cover Health Staff	34.00
Non-Health Staff	0.00
TOTALS	137.00

CHARTER CARE EXPENSE AS % OF TOTAL NET REVENUE

Medicare	Medicaid	Other Public	Private Insurance	Charity
42.0%	28.0%	0.1%	28.8%	0.0%
4,542,071	3,031,048	16,070	334,183	2,897,833
TOTALS	10,822,583	0	0	0

WAUWATONIA HEALTHCARE CENTER
175 THOMAS COURT
WAUWATONIA, IL 60084

Reference Numbers Facility ID 0008425
Health Service Area 008 Planning Services Area 087

Administrative Margaret Ryan
Contact Person and Telephone Date Completed 2/24/2011
MARGARET RYAN 847-930-6561

Regulation Agent Information Under 65 Years Old
Christopher Vance
501 N. Paulina
Chicago, IL 60601

FACILITY OWNERSHIP
LIMITED LIABILITY CO

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	DIAGNOSIS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggravated/Abused Spouse	Necropsies	7
Chronic Alcoholism	Encephalopathy	11
Developmentally Disabled	Blood Disorders	3
Drug Addiction	Various System Non Achiever	17
Medicaid Recipient	Alzheimer Disease	17
Mental Illness	Mental Illness	0
Non-Aboluntary	Developmental Disability	0
Non-Alcohol	Chronic System	40
Public Aid Recipients	Respiratory System	5
Under 65 Years Old	Digestive System	0
Unable to Self-Maintain	Genitourinary System Disorders	7
Violator Demented	Skin Disorders	0
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	5
Other Restrictions	Injury and Poisonings	6
No Restrictions	Other Medical Conditions	4
	Non-Medical Conditions	4
	TOTALS	123

Note: Reported restrictions derived by ?

Total Residents Discharged as Monthly 18

ADMISSIONS AND DISCHARGES - 2010

RESIDENTS IN USE, MEDICAID/MEDICARE CENTERED BEDS	PEAK	RESIDENTS ON 1/1/2010
LICENSED BEDS	135	117
AVAILABLE BEDS	135	271
BEDS IN USE	135	283
BEDS SET-UP	135	125
BEDS USED	135	125
PEAK	135	0
LEVEL OF CARE		
Nursing Care	0	0
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTAL BEDS	135	135

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	1.00
Director of Nursing	1.00
Registered Nurses	20.00
LPN's	5.00
Certified Aides	72.00
Cover Health Staff	34.00
Non-Health Staff	0.00
TOTALS	137.00

CHARTER CARE EXPENSE AS % OF TOTAL NET REVENUE

Medicare	Medicaid	Other Public	Private Insurance	Charity
42.0%	28.0%	0.1%	28.8%	0.0%
4,542,071	3,031,048	16,070	334,183	2,897,833
TOTALS	10,822,583	0	0	0

*Charity Expense does not include expenses which may be considered a community benefit.

LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 Wisconsin HealthCare & Rehab Wisconsin

Wisconsin HealthCare & Rehab
178 Thomas Court
Wausau, WI 54984
Reference Numbers Facility ID 800425
Health Services Area 008 Planning Service Area 007
Administrator Kathy Berg
Contact Person and Telephone
Kathy Berg
947-529-5551
Registered Agent Information
Dale
Complined
897008

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	RESTRICTIONS BY PRIMARY DIAGNOSIS
Aggravated Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medical Resident	0
Medicare Recipient	21
Mental Illness	0
Non-ambulatory	0
Non-liable	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Verbal Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	26	45	0	0	0	0	108
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	26	45	0	0	0	0	108

REVENUE BY FACILITY/EMPHASIS GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hispanic/Lat. Am.	0	0	0	0	0
White	108	0	0	0	108
Race Unknown	0	0	0	0	0
TOTAL	108	0	0	0	108

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

EMPHASIS	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expenses as % of Total Net Revenue
Medicare	44.1%	28.7%	0.0%	2.0%	24.0%	0.0%	100.0%
TOTAL	4,228,790	2,717,821	0	360,431	2,267,053	0	8,363,904

LONG-TERM CARE PROFILE-CALENDAR YEAR 2008 Wisconsin HealthCare & Rehab Wisconsin

Wisconsin HealthCare & Rehab
178 Thomas Court
Wausau, WI 54984
Reference Numbers Facility ID 800425
Health Services Area 008 Planning Service Area 007
Administrator Kathy Berg
Contact Person and Telephone
Kathy Berg
947-529-5551
Registered Agent Information
Dale
Complined
897008

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	RESTRICTIONS BY PRIMARY DIAGNOSIS
Aggravated Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medical Resident	0
Medicare Recipient	21
Mental Illness	0
Non-ambulatory	0
Non-liable	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Verbal Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	26	45	0	0	0	0	108
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	26	45	0	0	0	0	108

REVENUE BY FACILITY/EMPHASIS GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hispanic/Lat. Am.	0	0	0	0	0
White	108	0	0	0	108
Race Unknown	0	0	0	0	0
TOTAL	108	0	0	0	108

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

EMPHASIS	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expenses as % of Total Net Revenue
Medicare	44.1%	28.7%	0.0%	2.0%	24.0%	0.0%	100.0%
TOTAL	4,228,790	2,717,821	0	360,431	2,267,053	0	8,363,904

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2007 Wauconda HealthCare & Rehab Wauconda

Wauconda HealthCare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID: 600423
Health Services Area 008 Planning Services Area 087
Administrator Kathy Berg

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicare	Public	Insurance	Private	Charity	TOTALS	AVERAGE DAILY PAYMENT RATES
								SINGLE DOUBLE
Nursing Care	25	07	0	3	28	0	114	211 204
Skilled Under 22	0	0	0	0	0	0	0	0 0
ICF500	0	0	0	0	0	0	0	0 0
Skilled Care	0	0	0	0	0	0	0	0 0
TOTALS	25	07	0	3	28	0	114	

RESIDENTS BY RACE/ETHNICITY (GROUPING)

RACE	Medicaid	Medicare	ICF500	Skilled	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hispanic/Latino	114	0	0	0	114
White	0	0	0	0	0
Race Unknown	0	0	0	0	0
Total	114	0	0	0	114

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	20.00
LINAs	3.00
Certified Assist	50.00
Other Health Staff	7.00
Non-Health Staff	60.00
TOTALS	142.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
40.2%	33.6%	0.0%	1.3%	22.9%	0.0%	100.0%
3,833,827	3,123,420	0	132,408	2,011,128	0	8,760,500

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2007 Wauconda HealthCare & Rehab Wauconda

Wauconda HealthCare & Rehab
178 Thomas Court
Wauconda, IL 60084
Reference Numbers Facility ID: 600423
Health Services Area 008 Planning Services Area 087
Administrator Kathy Berg

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Neurosis	4
Ethanol/Alcoholic	6
Bipolar Disorder	0
Nervous System Non-Alzheimer	9
Alzheimer Disease	6
Mental Illness	0
Developmental Disability	45
Circulatory System	0
Respiratory System	7
Digestive System	3
Geriatric/geriatric Syndrome	3
Skin Disorders	0
Musculoskeletal Disorders	14
Injury and Poisonings	13
Other Medical Conditions	2
Non-factitious Conditions	0
TOTALS	114

ADMISSION RESTRICTIONS

- Aggravated Assault
- Alcohol/Alcoholism
- Developmental Disability
- Drug Addiction
- Medicaid Recipient
- Medicare Recipient
- Mental Illness
- Non-ambulatory
- Non-transferable
- Public Aid Recipient
- Under 18 Years Old
- Unable to Self-Medicate
- Verbal Abuse
- Infectious Disease w/ Isolation
- Other Restrictions
- No Restraints

Other: Repeated restriction allowed by ?

ADMISSIONS AND DISCHARGES - 2007

LEVEL OF CARE	Admissions	Discharges
Nursing Care	111	313
Skilled Under 22	0	310
Intermediate DD	0	114
Skilled Care	0	0
TOTALS	111	737

FACILITY UTILIZATION - 2007

BY LEVEL OF CARE PROVIDED AND PAYMENT SOURCE

LEVEL OF CARE	Medicaid	Medicare	Other	Private Insurance	Private Pay	Charity	TOTALS
Nursing Care	7949	18.1%	23517	161.1%	8917	41362	60.7%
Skilled Under 22	0	0.0%	0	0.0%	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0.0%
Skilled Care	0	0.0%	0	0.0%	0	0	0.0%
TOTALS	7949	18.1%	23517	161.1%	8917	41362	60.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2007

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0
45 to 59	1	0	0	0	0	0	1	2
60 to 74	3	0	0	0	0	0	3	3
75 to 84	8	4	0	0	0	0	12	12
85 to 94	4	33	0	0	0	0	37	37
95+	9	51	0	0	0	0	60	60
TOTALS	22	92	0	0	0	0	114	114

2005 ILLINOIS DEPARTMENT OF PUBLIC HEALTH LONG-TERM CARE FACILITY PROFILES

Reference Numbers 008 097 097 609435	ADMISSION RESTRICTIONS	RESIDENTS BY PRIMARY DIAGNOSIS
Wauconda Healthcare & Rehab 170 Thomas Court Wauconda, IL 60084	Aggressive/Anti-Social Chronic Alcoholism Developmentally Disabled Drug Addiction Medicaid Recipient Medicare Recipient Mental Illness Non-Ambulatory Non-Mobile Public Aid Recipient Under 65 Years Old Unable to Self-Medicate Other Restrictions No Restrictions	DIAGNOSIS Neoplasms 4 Endocrine/Metabolic 5 Blood Disorders 2 Nervous System 11 Alzheimer Disease 19 Muscle Disorders 0 Developmental Disability 0 Circulatory System 39 Respiratory System 7 Digestive System 3 Genitourinary System Disorders 2 Skin Disorders 1 Musculo-skeletal Disorders 9 Injuries and Poisonings 11 Other Medical Conditions 1 Non-Medical Conditions 0 TOTALS 114
Administrator Sandra Berner Contact Person and Telephone Jeff Dorck 847-524-5551	Date Completed 6/27/2006	Note: 1 equals restrictions used by facility
Registered Agent Information SCHWARTZ, LAWRENCE Y 7366 NORTH LINCOLN, SUITE 404 LINCOLNWOOD, IL 60084		
FACILITY OWNERSHIP LIMITED LIABILITY CO		

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS		PEAK BEDS		BEDS IN USE	MEDICARE CERTIFIED	MEDICAID CERTIFIED
	Male	Female	Set-Up	Used			
Nursing Care	117	117	117	117	114	125	125
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTAL BEDS	117	117	117	117	114	125	125

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2005

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	2	0	0	0	0	0	0	3	2	5
60 to 64	0	1	0	0	0	0	0	0	0	1	1
65 to 74	6	5	0	0	0	0	0	0	6	5	11
75 to 84	9	27	0	0	0	0	0	0	9	27	36
85 Over	10	51	0	0	0	0	0	0	10	51	61
TOTALS	28	86	0	0	0	0	0	0	28	86	114

110

PATIENT DAYS OF CARE - 2005

BY LEVEL OF CARE AND PATIENT TYPE

LEVEL OF CARE	2005			TOTAL	License		Set Up	
	Medicare	Medicaid	Other		Occ. Pct.	Occ. Pct.		
Nursing Care	4958	28647	6633	40238	94.2	94.2		
Skilled	0	0	0	0	0.0	0.0		
ICF/DD	0	0	0	0	0.0	0.0		
Shelter	0	0	0	0	0.0	0.0		
TOTALS	4958	28647	6633	40238	94.2	94.2		

PATIENT DAYS BY PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid	
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.
Nursing	4958	10.9	28647	62.8
Skilled	0	0.0	0	0.0
ICF/DD	0	0.0	0	0.0
TOTALS	4958	10.9	28647	62.8

Source: Health Systems Development
Illinois Department of Public Health
625 West Jefferson
Springfield, Illinois Phone: 217/782-3516

Note: Numbers preceding each section refer to the number of the question in the survey.
*Does not include Alzheimer diagnoses

2005 ILLINOIS DEPARTMENT OF PUBLIC HEALTH LONG-TERM CARE FACILITY PROFILES

Wauconda Healthcare & Rehab	008	609435				
RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE						
LEVEL OF CARE	Medicare	Medicaid	Other Public Insurance	Private Pay	Charity	TOTALS
Nursing Care	14	73	0	0	27	114
Skilled	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0
Shelter	0	0	0	0	0	0
TOTALS	14	73	0	0	27	114

ADMISSIONS AND DISCHARGES - 2005

A. Residents on January 1, 2005 112

B. Total Admissions 2005 225

C. Total Discharges 2005 223

D. Residents on December 31, 2005 114

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian or Pacific Islander	0	0	0	0	0
White	114	0	0	0	114
Unknown	0	0	0	0	0
Total	114	0	0	0	114

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE SINGLE DOUBLE

Nursing Care 217 185

Skilled Under 22 0 0

Intermediate DD 0 0

Shelter 0 0

RESIDENTS BY AGE GROUP, SEX AND PAYMENT SOURCE - DECEMBER 31, 2005

AGE GROUPS	Medicare		Medicaid		Other Public Insurance		Private Pay		Charity		TOTALS		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	3	2	0	0	0	0	0	0	3	2	5
60 to 64	0	0	0	0	0	0	0	0	1	0	0	1	1
65 to 74	1	2	3	2	0	0	0	0	1	0	6	5	11
75 to 84	3	2	7	17	0	0	0	0	1	0	9	27	36
85 Over	3	5	5	32	0	0	0	0	2	14	0	10	51
TOTALS	5	9	5	53	0	0	0	0	3	24	0	28	86

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	15.00
LPNs	3.00
Certified Aides	39.00
Other Health Staff	8.00
Non-Health Staff	41.00
TOTALS	108.00

FACILITY NOTES

Bed Change 5/9/2005
Added eight nursing care beds, total now 125 nursing care beds.

Source: Health Systems Development
Illinois Department of Public Health
625 West Jefferson
Springfield, Illinois Phone: 217/782-3516

Note: Numbers preceding each section refer to the number of the question in the survey.
*Does not include Alzheimer diagnoses.

ATTACHMENT LTC-19A

 Advocate Good Shepherd Hospital

450 West Highway 22 || Barrington, IL 60010 || T 847.381.0123 || advocatehealth.com

May 18, 2012

Ms. Kimberly Clawson
Lancaster Health Group
5061 N. Pulaski Road
Suite 203
Chicago, IL. 60630

Dear Ms. Clawson,

On behalf of Advocate Good Shepherd Hospital I am writing this letter in support of Wauconda Health Care's new addition to their skilled nursing facility. Wauconda Health Care is one of our skilled nursing facility partners who routinely serve persons who are discharged from our hospital. Based on the historical relationship between Advocate Good Shepherd and Wauconda health Care we anticipate that our referral relationship will continue in a similar volume as in the past years.

Sincerely,



Julie Mayer
Director, Community & Government Relations

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED VII)

Criterion 1125.590 - Staffing Availability

1. For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met.

2. Provide the following documentation:
 - o The name and qualification of the person currently filling the position, if applicable; and
 - o Letters of interest from potential employees; and
 - o Applications filed for each position; and
 - o Signed contracts with the required staff; or
 - o A narrative explanation of how the proposed staffing will be achieved.

The proposed project will add 40 additional nursing beds, which is only a 30% addition in capacity. Yet, the project is only proposing to increase total staffing full time equivalents (FTE) by only 33 FTE's or by 19.5 percent to a full complement of 202.2 FTE's. This will be accomplished through the benefit of economies-of-scale and through the sharing of the administrative and managerial staff. The seventeen proposed additional staff are mostly direct care or support staff. Please refer to the proposed staffing addition chart. Additionally, appended as

<u>Staffing</u>	
Position	FTE
MDS	1
Laundry	2
Maintenance	1
Housekeeping	4
Dietary	4
Manager (Sub Acute)	1
Licensed Practical Nurse	2
Registered Nurse	3
Certified Nursing Assistant	15
Total	33

ATTACHMENT LTC-23A, is the existing staffing pattern by position title. This project is atypical from traditional start-up projects as this is only a small addition to an already existing facility. The majority of personnel are in place. To achieve adequate staffing levels, the Applicant will start by reviewing and interviewing from the 20 R.N. employment applications currently on file. To further explain the internal process in recruiting and hiring staff

ATTACHMENT LTC-23

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED VIII)

Criterion 1125.590 - Staffing Availability (Continued ii)

a narrative description is provided below:

It is the policy of the organization to begin a comprehensive recruitment program approximately four to six months prior to the opening in order to insure that the new facility has all of the necessary positions filled with qualified personnel. Local advertising in the area newspaper and at area nursing schools has generally been sufficient in attracting the needed professional health care manpower. Furthermore, it is the policy of the organization to promote from within their company whenever possible which allows the transfer of top professionals in their field. However, recruitment is initiated through the following items:

1. A listing is obtained from the Illinois Board of Nurses in the geographic area of the proposed facility. Letters are mailed to announce the opening of the new facility in the specific areas and the positions that are available;
2. Advertisement in the local newspaper;
3. A special day for nurses will be held in the community. The nurses from the surrounding area will be invited to a special open house and tour of the facility. A film will also be shown to introduce the Applicant and its other Long-Term Care facilities, concluding with a question and answer session on the philosophy of the organization.

ATTACHMENT LTC-23

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED IX)

Criterion 1125.590 - Staffing Availability (Continued iii)

4. Announcement of the opening of the facility will be sent to the area Schools of Nursing. It is the philosophy of the organization that an innovative nursing program and a continual in-service training program enhancing the attraction of new employees and helps retain qualified and dedicated staff.

It should be noted that the subject facility is already very familiar with the employment situation of the area. The proposed employees will have paid health and dental insurance, continuing education credits, competitive wages, and a pension offered. With such a large number of existing employees one strong focus of recruitment will be by word of mouth by these existing employees to their respective communities. Furthermore, the Applicant will provide an upward mobility transfer for those employees within the market area.

Finally, there are five letters of support appended as **ATTACHMENT LTC-23B** from the Lake County High Schools Technology Campus who trains students as C.N.A.'s.

Thus, it does not appear that between the Applicant's experience and through the experience of the existing campus that there will be any difficulty in securing the needed health care manpower.

ATTACHMENT LTC-23

Wauconda Health Care Rehab Centre
CNA's Position Control

DAY SHIFT	Rate	FTE	PM SHIFT	Rate	FTE	Night SHIFT	Rate	FTE
15		21	15		21	10		14
Lori Rincluso, FT		1	Linda Altenbern, FT		1	Emilio Juarez, FT		1
Brandy Webster, FT		1	Hugo Gonzales, FT		1	Hugo Becerril, FT		0.8
Patricia Morales, FT		1	Ciga Mena, FT		1	Ana Alvarez, FT		1
Victoria Smith, PT		0.4	Marco Salazar, FT		1	Josa Ferrera, FT		1
Lily Carpenter, FT		1	Wilmer Rivera, FT		1	Steve Neumann, FT		1
Lorenzo Escobar, FT		0.8	Mofessa Schmitt, FT		0.9	John Pajo, FT		1
Claudia Arellano, FT		1	Edwin Martinez, FT		1	Estela Torres, PT		0.7
Lorena Arellano, FT		1	Migdalia Perez, FT		0.5	Sharyl Valenzuela, FT		0.5
Rosario Contreras, FT		0.9	Elizabeth Rico, FT		1	Javier Rico, FT		1
Rosa Guzman, FT		0.7	Raquel Larios, FT		1	Hilda Mendez, FT		0.8
Betsy Estrada, FT		1	Salvador Garcia, PT		0.8	Lilla Hernandez, PT		0.5
Aldo Vera, FT		1	Luz Martinez, FT		1	Griseida Gonzales, PT		0.3
Mike Mianulli, FT		0.8	Patricia Sanchez, FT		0.8	Sonia Valadez, PT		0.4
Marisela Gonzales, FT		1	Edith Rodriguez, PT		0.2	Roste Lopez, PT		0.2
Manuela Catalan, FT		1	David Matanda, FT		1	Martha Diaz, FT		1
Daisy Amador, FT		1	Dante Ramos, FT		1	Mavis Jackson, FT		0.9
Patricia Sanchez, PT		0.2	Mary Denaut, FT		1	Lea Contreras, FT		0.9
Michelle Woodhouse, OT		0.3	Lorenzo Escobar, PT		0.2	Adrian Arcilla, FT		1
Rita Garcia, PT		0.6	Jessie Gomez, FT		0.7			
Jesus Sanchez (weekend)		0.4	Arlana Nykaza, PT		0.3			
Erynn Ramirez, PT		0.2	Kaitlin Cristino, PT		0.3			
Nailay Fernandez (weekend)		0.4	Victoria Smith, PT		0.2			
Editha Narceda, PT		0.5	Edith Narceda, PT		0.2			
Silvira Albor, PT		0.4	Maria Wawrzyniak, PT		0.2			
Ana Lopez, PT		0.5	Ana Lopez, PT		0.5			
Rhonda Koga, PT		0.3	Andrea Ocampo, PT		0.3			
Susana Carrillo, FT		0.8	Stephanie Rivera, PT		0.2			
Maria Vasquez, PT		0.3	Julia Villegas, PT		0.3			
Lindsay Kaczynski, PT		0.3	Angel Pineda, PT		0.7			
Kathy Millet, FT		0.4	Juana Amador, PT		0.6			
Migdalia Perez, FT		0.2	Daniel Graham, PT		0.2			
Arlana Nykaza, PT		0.3	Juan Ramirez, PT		0.6			
Jesse Gomez, FT		0.2	Isabel Arteaga, PT		0.2			
Natelly Fernandez, PT		0.6	Sue Jensen, PT		0.3			
Stephanie Rivera, PT		0.2	Julio Meunier, PT		0.6			
Juana Amador, PT		0.1	Lilla Castillo, PT		0.4			
			Carol Perez, PT		0.1			
			Sara Miller, PT		0.3			
TOTAL		21.8	TOTAL		22.6	TOTAL		14
CNA SUPERVISORS								
1		1.4	1		1.4	1		1.4
						Maggie Alabawy		1
Debbie Lane		1	Adrian Serrano		0.9	Sheryl Valenzuela		.4
Rosa Guzman		0.2	Migdalia Perez		0.3			
Mike Mianulli		0.2	Salvador Garcia		0.2			
TOTAL		1.4	TOTAL		1.4	TOTAL		1.4

UPDATED BY :
LEONOR SALVADOR, RN DON
3/12/2012

Wauconda Health Care Rehab Centre
 General/ Administrative Position Control

	FTE	SOCIAL SERVICES	
		2	2.8
		Patricia Ukieja	1
		Kristin Kaczynski	0.8
Denise Casillas Dir of Billing	1	Bryan Sesterhahn	0.6
		TOTAL	2.4
Rita Wuchter Dir of Med Rec	1		
		Soc Service Director	
Lidia Magnelli Dir of HR	0.7	1	
Cheryl Hahn Dir of Admission	1	Robin Zazove	1
Reception			
Barbara Paul FT	1		
Taryn Dixon PT	0.5		
Allsa Dixon PT	0.4		
Caftin Meseenger PT	0.3		
Maintenance			
George Jamantoc	0.9		
Arnold Rice	1		
Administrator			
Margaret Ryan	1		



LAKE COUNTY HIGH SCHOOLS
TECHNOLOGY CAMPUS

(847) 223-6681 • FAX (847) 223-7363 • www.techcampus.org
19525 WEST WASHINGTON STREET • GRAYSLAKE, ILLINOIS 60030-1152

Dr. Linda L. Jedlicka
Executive Director

Julie D. Riddel
Principal

Christine R. Mascari
Business Manager

Date: March 15, 2012

To whom it may concern,

I am writing to support the new construction project proposed by Wauconda HealthCare and Rehabilitation Centre.

Wauconda Healthcare is an important part of this community and consistently provides exemplary care to persons in need of short-term rehabilitation, Alzheimer care and long-term care services. They have a good reputation in the community and serve persons through the region of Lake and McHenry Counties. Locally, they are the only skilled nursing facility in Wauconda.

Wauconda Healthcare has provided a quality learning environment for the Certified Nurse Assistant students of Lake County High Schools Technology Campus. The superior quality of patient care delivery has provided our students with the learning experiences needed to provide competent patient care in their future careers within the nursing profession.

This is an excellent organization and I am Eager to see them grow to serve the health care needs in this area. I am in support of this project.

Thank you,

Deborah Sterling, R.N., B.S., H.P.

Deborah Sterling
Clinical Instructor
Certified Nurse Assistant Program
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

PARTICIPATING SCHOOLS

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Libertyville • Mundelein • North Chicago • Richmond-Burton • Round Lake • Stevenson • Vernon Hills • Warren • Wauconda • Waukegan • Zion-Benton

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ATTACHMENT LTC-23B



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This is an excellent organization. I am eager to see them grow and continue to serve the health care needs in this area. I am in support of this project.

Thank you,

Kristi Martin
Assistant Principal
Certified Nurse Assistant Program Coordinator
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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ATTACHMENT LTC-23B



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Thank you,

Lisa Molidor, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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ATTACHMENT LTC-23B



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Thank you,

Chari Fugate, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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ATTACHMENT LTC-23B



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Thank you,

Lori Cook, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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ATTACHMENT LTC-23B

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED X)

Criterion 1125.600 Bed Capacity

The maximum bed capacity of a general LTC facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient/resident care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c (Long-Term Care Facilities)) over a two-year period.

This project is for the addition of only 40 nursing beds to an existing 135 bed long-term care nursing facility. Upon project completion the licensed capacity will be 175 nursing beds.

Therefore, this item is not germane.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XI)

Criterion 1125.610 - Community Related Functions

The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from those organizations.

Appended as **ATTACHMENT LTC-25A** are eight letters of community support for the proposed addition to Wauconda Healthcare and Rehabilitation Centre. These letters are from Senior Services Associates, Inc. office Coordinator Ms. Rita Boulden, Wauconda Area Chamber of Commerce, Inc. Executive Secretary Ms. Sandy Hartogh, The Federated Church of Wauconda Reverend Ryan M Sutton, and five letters from the Lake County High Schools Technology Campus: Clinical Instructor Ms. Deborah Sterling, Assistant Principal Ms. Kristi Martin, RN C.N.A. Instructors Ms. Lisa Molidor, Ms. Chari Fugate and Ms. Lori Cook.

ATTACHMENT LTC-25

Senior Services Associates, Inc.

Serving your loved ones today - and you tomorrow.

www.seniorservicesassoc.org

Kane County Senior Services
Greater Elgin Senior Center
101 S. Grove Avenue
Elgin, IL 60120
1-800-942-1724 • (847) 741-1404
Fax: (847) 741-2163

McHenry County Senior Services
McHenry Township Recreation Center
3519 N. Richmond Rd.
McHenry, IL 60051
1-800-330-3200 • (815) 344-3555
Fax: (815) 344-3593

Kane County Senior Services
Aurora Township Senior Center
900 N. Lake Street, Suite 205
Aurora, IL 60506
(630) 897-4035
Fax: (630) 897-6901

Kendall County Senior Services
908 Game Farm Road
Yorkville, IL 60560
(630) 553-5777
Fax: (630) 553-6979

McHenry County Senior Services
110 W. Woodstock Street
Crystal Lake, IL 60014
(815) 356-7457
Fax: (815) 356-7754

March 26, 2012

To Whom It May Concern:

I am writing to support the new construction project proposed by Wauconda HealthCare and Rehabilitation Centre.

Wauconda Healthcare is an important part of this community and consistently provides exemplary care to people in need of short-term rehabilitation and long term care services. They have a good reputation in the community and serve people in the regions of Lake, and McHenry Counties. Locally, they are the only skilled nursing facility in Wauconda.

I support the growth of this facility to serve the health care needs of seniors as their numbers continue to grow at a rapid rate.

Sincerely,



Rita Boulden
Office Coordinator

ATTACHMENT LTC-25A





Wauconda Area Chamber of Commerce, Inc.

100 N. Main Street • Wauconda, IL • 60084-1824 • 847-526-5580 • Fax 847-526-3059
Email: info@waucondachamber.org • www.waucondaareachamber.org

March 15, 2012

I am writing to support the new construction project proposed by Wauconda HealthCare and Rehabilitation Centre.

Wauconda Healthcare is an important part of this community and consistently provides exemplary care to persons in need of short-term rehabilitation, Alzheimer care and long-term care services. They have a good reputation in the community and serve persons throughout the region of Lake and McHenry Counties. Locally, they are the only skilled nursing facility in Wauconda.

This is an excellent organization and I am eager to see them grow to serve the health care needs in this area. I am in support of this project.

Sincerely,



Sandy Hartogh
Executive Director

ATTACHMENT LTC-25A

THE FEDERATED CHURCH

OF WAUCONDA, ILLINOIS 60084

200 S. BARRINGTON RD.
PHONE: (847) 526-8471
FAX: (847) 526-0966

REV. RYAN M. SUTTON, Pastor

March 8, 2012

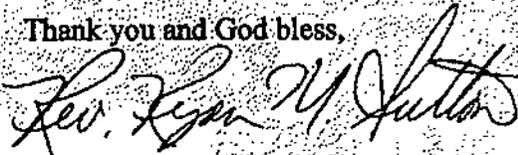
Dear Sir or Madam,

I am writing to support the new construction project proposed by Wauconda HealthCare and Rehabilitation Centre.

Wauconda Healthcare is an important part of this community and consistently provides excellent care to people in need of many healthcare services. They have a good reputation in the community and serve people from many areas. Currently they are the only skilled nursing facility in Wauconda.

I would love to see the Care Centre grow to serve the health care needs of this area. I am in support of this project.

Thank you and God bless,



Rev. Ryan M. Sutton
Pastor of The Federated Church of Wauconda



ATTACHMENT LTC-25A





LAKE COUNTY HIGH SCHOOLS
TECHNOLOGY CAMPUS

(847) 223-6681 • FAX (847) 223-7363 • www.techcampus.org
19525 WEST WASHINGTON STREET • GRAYSLAKE, ILLINOIS 60030-1152

Dr. Linda L. Jedlicka
Executive Director

Julle D. Riddel
Principal

Christine R. Mascari
Business Manager

Date: March 15, 2012

To whom it may concern,

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Wauconda Healthcare is an important part of this community and consistently provides exemplary care to persons in need of short-term rehabilitation, Alzheimer care and long-term care services. They have a good reputation in the community and serve persons through the region of Lake and McHenry Counties. Locally, they are the only skilled nursing facility in Wauconda.

Wauconda Healthcare has provided a quality learning environment for the Certified Nurse Assistant students of Lake County High Schools Technology Campus. The superior quality of patient care delivery has provided our students with the learning experiences needed to provide competent patient care in their future careers within the nursing profession.

This is an excellent organization and I am Eager to see them grow to serve the health care needs in this area. I am in support of this project.

Thank you,

Deborah Sterling, R.N., B.S., H.P.

Deborah Sterling
Clinical Instructor
Certified Nurse Assistant Program
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

PARTICIPATING SCHOOLS

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Libertyville • Mundelein • North Chicago • Richmond-Burton • Round Lake • Stevenson • Vernon Hills • Warren • Wauconda • Waukegan • Zion-Benton

ATTACHMENT LTC-25A

It is the policy of the Lake County High Schools Technology Campus not to discriminate on the basis of race, color, sex, national origin, age, religion, marital status, ancestry, national origin, physical and mental handicap or disability, sexual orientation, status as handicapped, or actual or potential marital or parental status, including pregnancy with respect to its educational programs, enrollment, activities or employment policy. This policy of non-discrimination is in compliance with Titles IX and VI and Section 504.



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Dr. Linda L. Jodlicka
Executive Director

Julle D. Riddel
Principal

Christine R. Mascari
Business Manager

Date: March 15, 2012

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Wauconda Healthcare has provided a quality learning environment for the Certified Nurse Assistant students of Lake County High Schools Technology Campus. The superior quality of patient care delivery has provided our students with the learning experiences needed to provide competent patient care in their future careers within the nursing profession.

This is an excellent organization. I am eager to see them grow and continue to serve the health care needs in this area. I am in support of this project.

Thank you,

Kristi Martin
Assistant Principal
Certified Nurse Assistant Program Coordinator
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

PARTICIPATING SCHOOLS

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ATTACHMENT LTC-25A

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Dr. Linda L. Jedlicka
Executive Director

Julie D. Riddel
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Date: March 15, 2012

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This is an excellent organization and I am Eager to see them grow to serve the health care needs in this area. I am in support of this project.

Thank you,

Lisa Molitor, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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Libertyville • Mundelein • North Chicago • Richmond-Burton • Round Lake • Stevenson • Vernon Hills • Warren • Wauconda • Waukegan • Zion-Benton

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ATTACHMENT LTC-25A



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Executive Director

Julie D. Riddel
Principal

Christine R. Mascari
Business Manager

Date: March 15, 2012

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This is an excellent organization and I am Eager to see them grow to serve the health care needs in this area. I am in support of this project.

Thank you,

Chari Fugate, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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Libertyville • Mundelein • North Chicago • Richmond-Burton • Round Lake • Stevenson • Vernon Hills • Warren • Wauconda • Waukegan • Zion-Benton

ATTACHMENT LTC-25A

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Date: March 15, 2012

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This is an excellent organization and I am Eager to see them grow to serve the health care needs in this area. I am in support of this project.

Thank you,

Lori Cook, RN CNA Instructor
Lake County High Schools Technology Campus
19525 West Washington ST.
Grayslake, Illinois 60030
847-223-6681

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ATTACHMENT LTC-25A

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XII)

Criterion 1125.620 - Project Size

The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix A, unless the additional GSF can be justified by documenting one of the following:

1. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
2. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix A;
3. The project involves the conversion of existing bed space that results in excess square footage.

Please find this section addressed under Section III, Part 1110.234), as this application form follows sections 1110 and 1120 and not the revised rules for long-term care under the new section 1125. It should be noted that the proposed project is in compliance with this criterion as the full bed compliment of 175 nursing beds will be provided in 80,878 gross square feet which calculates to 462 gross square feet per bed well within the upper range limit of 713 gross square feet per bed.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XIII)

Section 1125.630 Zoning

The applicant shall document one of the following:

- a) The property to be utilized has been zoned for the type of facility to be developed; (NOT GERMANE)
- b) Zoning approval has been received; or

As an existing structure and operating facility, the zoning for the project is in-place; however, due to the proposed expansion of the facility and the addition of land to the project, the property will have to receive another conditional permitted use variance.

- c) A variance in zoning for the project is to be sought.

Appended as ATTACHMENT LTC-27A, is a letter from the Village of Wauconda's Director of Planning and Zoning, Mr. Chris Miller. This letter indicates that this Applicant has initiated the process for a conditional permitted use of the property for the planned addition and its request will be first heard on the June 26, 2012 meeting by the Village Board Committee of the Whole.

ATTACHMENT LTC-27

**MAYOR
MARK F. KNIGGE**

**ADMINISTRATOR
DAVID GEARY**



**101 NORTH MAIN STREET
WAUCONDA, IL 60084
PHONE 847.526.9600
FAX 847.526.8809**

**CLERK
GINGER IRWIN**

**TRUSTEES
LINCOLN F. KNIGHT
JOHN F. BARBINI ED.D.
DOUG BUSTER
LINDA STARKEY
KEN ARNEWALD
CHUCK BLACK**

June 22, 2012

To Whom it May Concern:

Wauconda Health Care and Rehabilitation has submitted plans for review by the Village of Wauconda to accommodate a planned addition to their existing facility.

Wauconda Health Care has met with Village administrators to discuss the plans.

Currently the adjoining piece of property is zoned General Business (GB) and their new addition will require a Zoning Conditional Use Permit.

The Village Board Committee of the Whole will hear their first presentation on June 26, 2012. The rezoning process is ongoing.

Sincerely,

A handwritten signature in black ink that reads "Chris Miller".

Chris Miller
Director of Planning & Zoning

ATTACHMENT LTC-27A

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XIV)

Criterion 1125.640 - Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in Section 1125.210(c) for each category of service involved in the proposal.

For beds that have been approved based upon representations for continuum of care (Section 1125.560(a)) or defined population (Section 1125.560(b)), the facility shall provide assurance that it will maintain admissions limitations as specified in those Sections for the life of the facility. To eliminate or modify the admissions limitations, prior approval of HFSRB will be required.

Appended as **ATTACHMENT LTC-28A** is a letter from Mr. Christopher Vicere, Vice-President – Finance for the Applicant for the project attesting to their understanding of this criterion.

ATTACHMENT LTC-28



HealthCare & Rehabilitation Centre
Trusted care. Peace of mind.

May 9, 2012

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

RE: Wauconda Health Care & Rehabilitation Centre, LLC Criterion 1110.1730(K)

Dear Ms. Avery:

This letter is to attest that Wauconda HealthCare & Rehabilitation Centre, LLC, by the second year of operation after project completion, will achieve and maintain 90% occupancy. Our ability to maintain this occupancy level could be affected by factors outside our control, such as natural disasters, physical plant problems, regulatory or reimbursement changes, interruption or failure of electricity or telephone, restrictive governmental laws and regulations, riots, fuel shortages, accidents or casualties, directly or indirectly causes the occupancy rate to be below 90%, or other demographic issues outside our control.

Sincerely,

Christopher Vicere
Vice President – Finance

ATTACHMENT LTC-28A

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XV)

Section 1125.650 Modernization

- a) If the project involves modernization of a category of LTC bed service, the applicant shall document that the bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:
- 1) High cost of maintenance;
 - 2) Non-compliance with licensing or life safety codes;
 - 3) Changes in standards of care (e.g., private versus multiple bed rooms); or
 - 4) Additional space for diagnostic or therapeutic purposes.

The proposed project involves modernization of the nursing category of Long-Term Care bed service as the bed areas to be modernized are functionally obsolete due to the ever evolving nursing care industry in which more private rooms are needed and desired. The issues in maintaining multiple bed-bedrooms are more than just marketability, although that is a significant influence. The industry has seen all new hospitals comply with new facilities providing long-term care, yet long-term care falls behind. The other important change in standards of care comes from infection control and privacy issues. Infection control issues more readily effect utilization levels as Wauconda has 2-three bed ward rooms that are connected by a bathroom to an adjoining room and if a resident need to be isolated, it is not only the two other beds in that room that have to be vacated but also the adjoining room's beds. Please note that the project being proposed will address and eliminate this issue. The issue of privacy is one that is essential also to personal dignity and self awareness. Residents do not appreciate having to share personal issues of toileting with their roommates let alone the residents who are in the adjoining room. Medical issues are not as private if one is in a two or three bed resident room. Finally, as set for the in the Health Facilities and Services Planning Act (20 ILCS 3960.Section 12.15) it is

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XVI)

Section 1125.650 Modernization (Continued ii)

an objective of the Act to improve the overall number of private bed rooms within the facility. It is for these issues that this project is being proposed.

b) Documentation shall include the most recent:

- 1) IDPH and CMMS inspection reports; and
- 2) Accrediting agency reports.

Appended as **ATTACHMENT LTC-29A** are copies of the facility's most recent CMMS surveys. A letter from the Applicant's architect asserting that the facility is in excellent condition and meeting of all applicable life safety, fire and other local and State codes is appended as **ATTACHMENT LTC-29B**. It was for this reason that the project was determined to be for modernization and expansion instead of total replacement.

c) Other documentation shall include the following, as applicable to the factors cited in the application:

- 1) Copies of maintenance reports;
- 2) Copies of citations for life safety code violations; and
- 3) Other pertinent reports and data.

A letter from the Applicant's architect asserting that the facility is in excellent condition and meeting of all applicable life safety, fire and other local and State codes is appended as **ATTACHMENT LTC-29B**. It was for this reason that the project was determined to be for modernization and expansion instead of total replacement.

ATTACHMENT LTC-29

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA (CONTINUED XVII)

Section 1125.650 Modernization (Continued iii)

- d) Projects involving the replacement or modernization of a category of service or facility shall meet or exceed the occupancy standards for the categories of service, as specified in Section 1125.210(c).

Appended as ATTACHMENT LTC-29C is the most recent IDPH Annual Facility Questionnaire data (Wauconda's IDPH facility profile) documenting that in CY2010 this facility had an occupancy of 90% (89% to be precise) to include the increase in licensed capacity. Moreover, the Applicant reported within this application that in the 12-months ending February 2012, patient days of 44,034 which calculates to a utilization rate of 89.1% (44,034 patient days/366 day in the year/135 licensed nursing beds). Therefore, this project substantially meets the occupancy standards for the nursing category of service as set forth in Section 1125.210(c).

ATTACHMENT LTC-29

Midwestern Consortium
Division of Survey & Certification



CMS Certification Number (CCN): 145887

December 22, 2011
By Certified Mail and Facsimile

Margaret Ryan, Administrator
Wauconda Healthcare and Rehab
176 Thomas Court
Wauconda, IL 60084

Post-it® Fax Note	7671	Date	
To	MARGARET RYAN	From	TAMARA BOYD
Company	Wauconda HC	Co.	CMS
Phone #		Phone	(312) 353-1522
Fax #	(815) 526-7549	Fax #	

Dear Ms. Ryan:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS
Cycle Start Date: October 27, 2011

STATE SURVEY RESULTS

On October 27, 2011, a health survey and a Life Safety Code (LSC) survey were completed at Wauconda Healthcare and Rehab by the Illinois Department of Public Health (IDPH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at Scope and Severity (S/S) level G, cited as follows:

- F309 – S/S: G – 483.25 -- Provide Care/Services for Highest Well Being

The IDPH agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

On December 14, 2011, the IDPH conducted a revisit of your facility. The revisit revealed that all of the deficiencies related to the health portion of the survey were corrected. However, your facility continues to be out of substantial compliance based on outstanding LSC deficiencies.

FEDERAL MONITORING SURVEY

On November 8, 2011, the IDPH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by November 26, 2011. However, on December 15, 2011, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

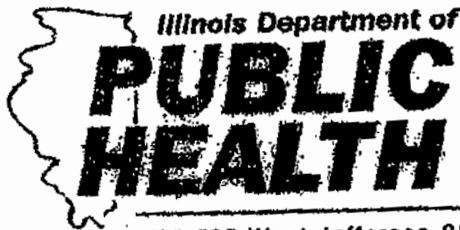
- K144 – S/S: F – NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601-5519

Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

ATTACHMENT LTC-29A



Pat Quinn, Governor

625-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Margaret Ryan, Administrator
Wauconda Healthcare And Rehab
176 Thomas Court
Wauconda, IL 60084

Provider #: 145887/0044859
Cycle Date: October 27, 2011
Survey Date: October 27, 2011
Survey Type: Annual Health

Dear Ms. Ryan:

On October 27, 2011, an inspection was conducted at Wauconda Healthcare And Rehab by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare/Medicaid programs. In response to deficiencies cited during that survey, the facility has submitted documentation to refute the deficiencies. That documentation has been reviewed by staff of the Department and the following changes have been made to the "Statement of Deficiencies."

F 317 G was reduced to a scope and severity of a D - F 317 D. An amended Statement of Deficiencies (CMS 2567L) is enclosed.

These changes have NOT resulted in a change in proposed, imposed or recommended remedies previously sent to the facility in the "Initial Notice" dated November 8, 2011.

If you have any questions regarding this notice, please contact my staff at (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

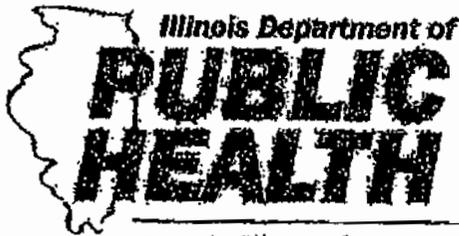
Sincerely,

Richard L. Dees, Chief
Bureau of Long-Term Care

cc: Centers for Medicare and Medicaid Services
Illinois Department of Healthcare & Family Services
Illinois Department on Aging
Lawrence V. Schwartz, Registered Agent
File 2

C-3/ksh

ATTACHMENT LTC-29A



Pat Quinn, Governor

525-585 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

November 8, 2011

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Ms. Margaret Ryan, Administrator
Wauconda Healthcare And Rehab
176 Thomas Court
Wauconda, IL 60084

Reference: Provider ID: 145887 / 0044859
 Cycle Date: October 27, 2011
 Survey Date: October 27, 2011
 Survey Type: Health Survey
 LSC Survey: October 27, 2011

Dear Ms Ryan:

On October 27, 2011, an inspection was conducted at Wauconda Healthcare And Rehab by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare/Medicaid programs. As a result of that inspection, the facility was determined to not be in "Substantial Compliance" with regulatory requirements as found in Title 42, Code of Federal Regulations. A *Statement of Deficiencies* is enclosed (See Enclosure #1). An explanation of the scope and severity assigned to each deficiency can be found on Enclosure #2.

The facility must submit a Plan of Correction (POC) for all deficiencies at the "B" level or higher. "A" deficiencies must be corrected, but do not require a written POC. All required POC's must be submitted to the Department within 10 days after receipt of the written "Statement of Deficiencies" (CMS Form 2567L). The POC cannot be submitted on the CMS-2567. Only the first page of the CMS-2567 must be submitted with the signature of the facility's representative and the date. The POC itself should be on separate sheets of paper which are attached to the first page of the CMS-2567. Please do not use proper names or trademarks in the POC. The POC is not to be used to dispute a deficiency or to make comments about the survey process. Information disputing a deficiency may be provided through the IDR process on separate sheets of paper, and comments about the survey process may be provided on the Provider Feedback Survey.

Improving public health, one community at a time

printed on recycled paper

ATTACHMENT LTC-29A

Each POC must include:

- Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.
- Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.
- Dates when corrective action will be completed. (To avoid remedies for this survey cycle, all deficiencies must be corrected no later than November 26, 2011).

Failure to submit a POC which includes the above-listed components within 10 days following receipt of the written "Statement of Deficiencies" may result in imposition of remedies, effective as soon as notice requirements are met.

Note: See the ORANGE ATTACHMENT that explains the Plan of Correction Requirements for Life Safety Code.

Note: Waivers may only be considered for "Room size/occupancy" Tag F458; "Registered Nurse Staffing" Tag F354 and Life-Safety Code requirements. (See Enclosure #4.)

Facilities with no deficiencies or deficiencies at the "A", "B" or "C" levels are considered to be in "Substantial Compliance" with the regulations and will continue to be certified. Facilities NOT in "Substantial Compliance", i.e., deficiencies at level "D" or above, may be subject to remedies, including:

- Denial of Payment for all *new* Medicare/Medicaid Admissions;
- Denial of Payment for *all* current Medicare/Medicaid Residents;
- Civil Money Penalties of up to \$10,000.00 per day or per instance;
- Transfer of Residents;
- Transfer of Residents with facility closure;
- Termination of the provider agreement;
- Temporary Management of the facility
- State Monitoring of the facility;
- Directed Plan of Correction;
- Directed In-Service Training.

Those facilities that have not achieved "Substantial Compliance" within 3 months following the survey will be subject to mandatory denial of payment for all new program admissions and mandatory termination from the Medicare/Medicaid programs if "Substantial Compliance" is not achieved within six months following the survey.

As a result of the above-referenced survey, proposed remedies for this facility are the following:

- **Civil Money Penalty of \$200.00 per day effective October 27, 2011.**

The facility will be allowed an "opportunity to correct" the cited deficiencies before remedies are actually imposed. If all deficiencies are found to be in "Substantial Compliance" at the first revisit after the opportunity to correct date, the Department will withdraw its proposal that remedies be imposed. If however upon revisit, "Substantial Compliance" with ALL regulations has not been achieved, the Department will impose or recommend to the federal Centers for Medicare and Medicaid Services (CMS) to impose the above-listed proposed remedies. The Department may also recommend or impose an increase or decrease in those proposed remedies based upon the results of the revisit. Generally, all imposed civil money penalties will be effective from the date of the original survey and will accrue until the date the facility achieves "Substantial Compliance" with the regulations or is terminated from the Medicare/Medicaid programs. Should CMS or the Department determine that termination or any other remedy is warranted (based on a subsequent survey), you will be provided with a separate formal notification of that determination.

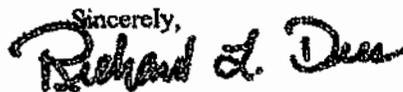
Before a revisit will be scheduled, the facility must provide to the Department an acceptable POC for ALL deficiencies, except level "A" deficiencies. An acceptable POC will also serve as the facility's "Allegation of Compliance" thereby signifying that the facility attests that it will be in "Substantial Compliance" with all federal certification requirements by the date stated in the above paragraph. The Department will presume that the facility will be in "Substantial Compliance" based upon the acceptable POC and a revisit will be conducted to verify compliance.

The facility may request an "Informal Dispute Resolution" (See Enclosure #3) to challenge any deficiency that renders the facility not in substantial compliance ("D" or above). *The Informal Dispute Resolution process will not delay the effective date of any enforcement action!* If the facility requests an Informal Dispute Resolution without submitting an acceptable POC and the Department's decision, as a result of the dispute resolution process does not result in the deletion of the deficiency, please be advised that the Department will then proceed to impose or recommend imposition of the remedies.

Please submit all documents or other materials relating to this survey to:

Illinois Department of Public Health
Division of Long-Term Care Quality Assurance
525 West Jefferson Street, 5th Floor
Springfield, Illinois 62761-0001
ATTN: Ted Zelinski

If you have any questions concerning this notice, please contact my staff at the address above or telephone (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,


Richard L. Dees, Chief
Bureau of Long-Term Care

Encls:

cc: Illinois Department of Healthcare & Family Services
Illinois Department on Aging
Guardianship & Advocacy Commission
Division of LTC-FO
Mr. Lawrence Schwartz, Registered Agent
File 2

a5/LJK

ATTACHMENT LTC-29A

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 148887	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2011
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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification.	F 000		
F 164 88-D	VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT Wauconda Healthcare and Rehab is in compliance with Subpart U, 77 Illinois Administrative Code, Section 300.7000 483.10(e), 483.75(f)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that residents are provided privacy when care is being given. This failure is for 1 resident (R10) in the sample of 24, and 2 residents (R25, R26) in the supplemental sample. The findings include: 1. On 10/26/11 at 9:10 AM E9 (CNA) was observed providing incontinence care to R10. E9 left R10 naked and exposed from the waste down while he went into the bathroom to obtain a wash clothe to clean the resident. E9 said that he was not aware of the need to cover the resident. 2. On 10/25/11 at 3:51 PM E10 and E11 (CNA's) were observed applying a blood pressure cuff to R26's lower leg. R26 was in bed and the door was open. The privacy curtain was not pulled. R26's pant leg was pulled up and he was viewable from the hallway. 3. On 10/26/11 at 10:35 AM Z1 (Physician) was observed examining R25 in the common area outside the dining room.	F 164			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241			

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F 241	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to promote the dignity of residents. This is for 2 residents (R15 and R16) in the sample of 24.</p> <p>The findings include:</p> <p>1. On 10/25/11 at 3:50 PM E10 (CNA) entered R16's room without knocking and without asking permission to enter. When R16 asked E10 is she could help him, he said that he needed to take R16's vitals.</p> <p>On 10/26/11 at 2:20 PM R16 said that staff enter her room all the time without knocking or asking permission to enter.</p> <p>2. On 10/25/11 at 9:10 AM R15 was in a wheelchair facing the wall in her room. E9 (CNA) was in the room providing care to R15's roommate. On 10/27/11 at 8:30 AM R15 was again in a wheelchair facing the wall in her room. E9 was again providing care to R15's roommate. E9 said that he placed R16 facing the wall because he needed to move her out of the way to take care of her roommate.</p> <p>3. On 10/26/11 at 11:05 AM E12 (Housekeeper) was observed speaking a foreign language in the hallway (300). Residents were present in the hallway at the time.</p> <p>On 10/27/11 E2 (DON) said that E12 was coached on not speaking a foreign language in front of residents.</p>	F 241		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	<p>Continued From page 3 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed to address a resident's poor positioning and failed to identify a rash resulting from the resident's poor position. These failures resulted in 1 resident (R15) developing a neck rash with fungus. The sample size is 24.</p> <p>The findings include:</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:46 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM and 10:55 AM.</p>	F 309		

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F 309	<p>Continued From page 4</p> <p>On 10/26/11 at 10:55 AM E6 (Restorative Aide) said that R15 usually keeps her head down and her eyes closed. E6 lifted up R15's head slightly and held it. A deep red rash was noted in the skin folds of R15's neck. E3 (Restorative and Wound Nurse) was present at this time. E3 said that she was not aware that R15 had a rash on her neck.</p> <p>On 10/26/11 at 11:10 AM Z1 (Doctor) examined R15's neck. Z1 said that R15 had a rash with fungus. Z1 said that he ordered anti-fungal cream.</p> <p>On 12/26/11 at 12:36 PM E7 (CNA) said that she noticed that R15 had a rash on her neck in the morning but did not tell the nurse because she thought the nurse new about it.</p> <p>On 12/28/11 at 11:20 AM E8 (Nurse) said that she was not aware that R15 had a rash on her neck.</p>	F 309		
F 317 SS=G	<p>483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 317		

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F 317	<p>Continued From page 5</p> <p>review the facility failed to assess, provide interventions, and care plan to prevent limitations in range of motion to the neck. These failures resulted in the development of a severe range of motion limitation of the neck for 1 resident (R15), out of 6 reviewed for range of motion, in the total sample of 24.</p> <p>The findings include:</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 has bilateral functional limitations in range of motion of the upper extremity (shoulder, elbow, wrist, hand), and lower extremity (hip, knee, ankle, foot) according to the 9/14/11 MDS. The facility's Restorative Functional Assessment dated 9/14/11 does not assess R15's limited range of motion of her neck. Physical Therapy notes dated 1/5 - 1/12/11 document that R15 needs reminders to keep her head up and sit upright. R15's therapy discharge recommendations for restorative care dated 2/3/11 state "Encourage pts head position to be up." R15's Care Assessment Areas dated 3/18/11 does not assess R15's behavior of holding her head down. R15's care plan does not identify R15's behavior of holding her head down, and no interventions were planned.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of</p>	F 317		

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F 317	<p>Continued From page 6</p> <p>her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM, 10:55 AM and 2:25 PM.</p> <p>On 10/26/11 E3 (Restorative Nurse) said that there was no prior assessment of R15's range of motion to her neck. E3 said that the restorative functional assessment does not include a section for evaluating range of motion to the neck. On 10/27/11 at 12:10 PM E3 said that R15 did not have a care plan addressing R15's behavior of holding her head down and no interventions were planned.</p> <p>On 10/26/11 at 1:50 PM E6 (Restorative Aide) said that R15 has been holding her head down more in the past 3 - 5 months. E6 said that R15 could previously holding her head up on her own, but now she cannot hold it on her own. E6 said "sometimes I turn her head" because she won't do it on her own.</p> <p>On 10/17/11 at 8:55 AM Z2 (Physical Therapist Assistant) said that when R15 was admitted in March of 2010 she did not have any neck issues according to the therapy notes. Z2 said that R15 was picked up by therapy again in January 2011 after she had a fall. Z2 said that at that time they noticed that R15 was starting to put her head down and needed cues to hold her head up and stand upright. Z2 said that no range of motion measurements were taken of R15's neck because range of motion wasn't a problem. Z2 pointed out that when R15 was discharged from therapy on 2/3/11 it was recommended that staff encourage R15 to hold her head up.</p>	F 317		
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F 317	Continued From page 7 On 10/27/11 Z3 (Physical Therapist) completed an assessment on R15. Z3 said that R15 cannot hold her head up on her own. Z3 said that R15 has severe limits to range of motion upon left rotation of the head. Additionally, Z3 said that R15 has functional limits to range of motion to all areas of her neck. Z3 said that R15 requires proper positioning/body alignment to reduce further reductions in range of motion.	F 317		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to provide a safe environment by not ensuring treatment cart, emergency cart, boiler room, storage area, circuit breaker electrical panel were kept locked and are not accessible to cognitively impaired residents. This deficient practice was observed in 1 of 3 nursing station units (Town Square area). This nursing unit is connected with easy access to 3 resident hallways and a lounge area. Findings include: 1) During the initial tour with	F 323		

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F 323	<p>Continued From page 8</p> <p>E3(restorative/treatment nurse) on 10/24/2011 at 11:05 A.M., the boiler was not locked. The boiler room is adjacent to the nursing unit(Town Square unit). Inside the boiler room was an unlocked circuit electrical panel. There were also boxes of screws and light bulb on top of a maintenance cart that was found inside the boiler room.</p> <p>2) On 10/24/2011 at 11:10 A.M., with E3, the (tub room) in 300 wing is use as a storage area. This storage area was not locked when observed. There was a floor polisher machine that has a long extension of an electrical cord and was dangling from the machine and was next to the unlock door.</p> <p>3) On 10/26/2011 from 10:16 A.M. to 10:30 A.M., there was an unattended treatment cart that was not locked. Inside the treatment cart were multiple tubes/ containers of wound cleansing solution, cream and ointments for wound treatments. This treatment cart was in the hallway next to the Town Square nursing station. This nursing station is an open unit that is connected to resident's lounge and 3 residents's hallways. On 10/26/2011 at 10:35 A.M., E3 (restorative/treatment nurse) stated she forgot to lock the treatment cart. E3 also confirmed that there are residents who are cognitively impaired and wanders around the unit/hallway/lounge area.</p> <p>4) During the environmental tour of the facility with E17 (Maintenance Director), E18 (Housekeeping Supervisor) and E19 (Maintenance Supervisor) on 10/26/11 at 11:50 AM, an emergency cart was observed outside the Town Square nursing station. On top of this emergency cart were two (2) tubes of glucagon</p>	F 323		

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F 323 F 363 SS=D	<p>Continued From page 9</p> <p>medications (emergency medication to quickly elevate blood sugar level), visible and accessible to the residents in the 100, 200 and 300 units.</p> <p>On 10/26/11 at 11:55 AM, E20 (Assistant Director of Nursing) stated that there are confused and mobile residents in these units.</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility to follow the menu for puree diet types, and failed to follow the recipe when preparing pureed diets. This is for 2 of 2 residents receiving puree diets, 1 (R1) in the sample of 24, and 1 (R26) in the supplemental sample.</p> <p>The findings include:</p> <p>The facility offers multiple choice menus for all diet types according to the Spring/Summer 2011 Menu Diet Extensions. The choices for puree diet types include puree salad, puree garlic bread and puree pasta in garlic sauce.</p> <p>On 10/24/11 at 11:30 AM E13 (Cook) was observed preparing the pureed diet types in the kitchen. E13 did not follow any recipes when preparing the pureed diets. E13 did not prepare</p>	F 323 F 363		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2011
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 363	Continued From page 10 puree salad, puree garlic bread or puree pasta in garlic sauce. On 10/25/11 at 11:30 AM E14 (Dining Services Manager) said that the salads are not prepared for the mechanical (puree) diet types because their speech therapist said not to serve it. E14 said that no substitution was made. On 10/25/11 at 2:22 PM E15 (Food Service Director) said that he did not know why the cook did not puree the garlic bread and the pasta. E15 said that the cook should have pureed these items. E13 was observed preparing the pureed beef and vegetable soup. E13 place several cups of beef and vegetable soup in the blender and blenderized the mixture. The end product had the consistency of thin liquid. E13 did not add any thickener to the mixtures. The Puree Beef Vegetable Soup recipe states "Add thickener while processing til HONEY THICK."	F 363			
F 371 SS=F	Two residents (R1 and R26) receive puree diets according to the facility's diet list. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that sanitation practices were followed in the kitchen in the areas of food preparation and storage, hand washing, cleaning and storage of dishes and utensils, and storage of pans. This failure has the potential to affect all 122 residents residing at the facility.</p> <p>The findings include:</p> <p>On 10/24/11 at 11:30 AM E13 (Cook) was observed preparing the pureed diets. E13 did not change her gloves or wash her hands after touching soiled areas, such as, the garbage and soiled pans. For example, after touching the garbage lid E13 touched the inside of a pan with her soiled glove. E13 then scooped the pureed vegetable mixture into the same pan.</p> <p>On 10/24/11 at 11:20 AM the facility's hot water sanitizing dish machine was not reaching the appropriate minimal wash temperature of 140 degrees Fahrenheit (F). Additionally, the facility's Dishmachine Temperature Log for October 2011 showed that the final rinse temperature failed to reach 180 degrees F on 17 occasions. No corrective action was documented on the form under the section "Action Taken if Out of Range." The facility's Dish Machine Protocol dated March 2006 documents that was temperatures should be between 155 - 160 degrees F, and final rinse temperatures should be between 180 - 195 degrees F. Additionally the policy states "Communicate any issues to manager."</p>	F 371		

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F 371	Continued From page 12 Multiple issues were identified regarding the cleanliness of dishes, utensils and pans. For example, more than a dozen plates were found soiled with foodstuff, i.e. dried eggs, and/or flecks for debris. These plates were identified as clean and stored in the plate warming machine at the steam table. E15 (Dining Services Director) was present for this observation. The meat slicer was covered with a large black plastic bag and was identified as clean by E15. The slicer was soiled with crumbs and food flecks. All three utensil drawers were soiled with standing water and food debris that was in contact with the clean utensils in the drawer. Two of the utensils had chunks of plastic missing from them and were in poor condition. The 3-tier carts used to transport food and drink was visible soiled with food stuff. The pans stored in the clean area next to the dish machine were noted to be wet, and stacked on top of each other. E16 (Pot and Pan Washer) was observed stacking a wet container on top of other containers in the clean area. The facility's Manual Pot & Pan Wash Procedure dated March 2006 states "Turn all pans upside down or inverted and allow to air dry completely before any item(s) are placed on designated storage shelving."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

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F 441	<p>Continued From page 13</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that staff did not contaminate clean linens and handled in the manner to prevent the potential spread of infection. This was observed in 2 of 3 resident's units in the facility.</p>	F 441			

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F 441	Continued From page 14 Findings include: 1) During the initial tour with E3(restorative/treatment nurse) on 10/24/2011 at 10:45 A.M., E4 (housekeeper) was changing bed linens in room 104-1. E4 placed set of clean linens and blanket on top of an open drawer next to the bed of 104-2. E4 stated that she will use the set of clean linens for beds 1 and 2 in room 104. 2) On 10/24/2011 at 10:50 A.M., E4 (housekeeper) was changing linens in 111-2. E4 was using linens/blanket that was on top of bed in 111-1. 3) On 10/24/2011 at 11:00 A.M., E5 (housekeeper), carried multiple sets of linens and blanket by holding these lines next to her upper body and arms. E4 brought all these set of clean linens and placed on top of bed in room 306-1. E5 proceeded to change linens in 306-2 and was using the linens that was placed on top of bed 1. E5 stated that she will also use some of the linens in another room (302). Review of the facility's policy for linen handling showed to carry linens away from body, should not touch the body, carry linens into a resident room one set per bed at a time and that linens should not be stored in the resident's drawers for any reason.	F 441		

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K 000	INITIAL COMMENTS An Annual Life Safety Code (LSC) Certification Survey was conducted by the Illinois Department of Public Health. At this survey, Wauconda Healthcare and Rehab, Wauconda was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 19 Existing Health Care. The facility is a one story building with partial basement not used by residents. The building construction type was determined to be a Type II (0 0 0). Facility was fully sprinklered having coverage in all areas. The building has a fire alarm system with smoke detection tied to fire alarm in corridors, areas open to corridors, common spaces and some resident rooms. The facility has a capacity of 135 licensed beds and had a census of 121 residents at the time of the survey.	K 000		
K 022 SS=E	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 022	Continued From page 1	K 022			
K 025 SS=E	<p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide exit signs marked to reach the exits per NFPA 101, 2000 edition, section 7.10.1.4. This deficient practice could affect an indeterminable number of staff if these exits were required to be used during a building evacuation.</p> <p>Findings include:</p> <p>Based on observation during a facility tour on 10/27/11 this surveyor and E1 (Maintenance Director) observed that there was no direction exit sign installed in basement corridor to mark exit access path to front exit stair. 11:35 AM</p> <p>Interview with E1 at time of observations confirmed the findings.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p>	K 025			

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K 025	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interview the facility failed to provide properly constructed and fire stopped smoke barriers to provide compartmentalization of the facility in accordance with NFPA 101, 2000 Edition, Section 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 and 8.3. This deficient practice could affect 50 of 121 residents, as well as an indeterminable number of staff and visitors if smoke from a fire were allowed to pass from one smoke compartment to another. Findings include: Based on observation during the facility tour on 10/27/11 at 12:35 PM this surveyor, E1 (Maintenance Director) observed holes in the smoke wall to 300 Wing, above cross corridor smoke door, above ceiling at penetration of two metal conduits. Interview with E1 at the time of observation confirmed the findings.	K 025			
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029			

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K 029	Continued From page 3 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide 1 hour fire rated construction and smoke resistant enclosure to protect hazardous rooms from the exit corridor in accordance with NFPA 101, 2000 Edition, Sections 19.3.2.1, 8.4.1, 19.3.5.4. Doors shall be self closing. This deficient practice could affect an indeterminate number of staff if a fire were allowed to spread from a hazardous area. Findings include: Based on observations during facility tour on 10/27/11 this surveyor and E1 (Maintenance Director) observed that door to Soiled Linen room in basement was lacking latching hardware . 11:20 AM Interview with E1 at the time of observation confirmed the findings.	K 029			
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 038			

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K 038	Continued From page 4 facility failed to provide exit access that is readily accessible to a public way (open parking lot, street, etc) at all times in accordance with the requirements of NFPA 101, 2000 Edition , Section 7.1 This deficient practice could affect indeterminable number of staff if evacuation via a deficient means of egress was necessary. Findings include: During the facility tour on 10/27/11 at 11:25 AM, this surveyor and E1 (Maintenance Director) observed that exit stair from basement to front of building discharges on grass lawn. No hard walking surface was provided to public way. Interview with E1 at the time of the observation confirmed the findings.	K 038			
K 040 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide exit access and exit doors in accordance with the requirements of NFPA 101, 2000 Edition , Section 19.2.3.5 This deficient practice could affect indeterminable number of staff if evacuation via a deficient means of egress was necessary. Findings include: During the facility tour on 10/27/11 at 11:30 AM,	K 040			

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K 040	Continued From page 5 this surveyor and E1 (Maintenance Director) observed that exit door to exit stair from basement to front of building was blocked from fully opening by dryer vent enclosure constructed behind the door. Clear opening of the door was restricted to 20 inches.	K 040			
K 045 SS=E	Interview with E1 at the time of the observation confirmed the findings. NFFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, facility failed to provide or maintain illumination to the means of egress including exit discharge such that failure of any single light fixture (bulb) would leave an area in darkness in accordance with NFFPA 101 Life Safety Code, 2000 Edition, Sections 7.8, 19.2.8, 19.2.8. This deficient practice could affect 80 of 121 residents as well as an indeterminable number of staff and visitors if lighting failed to operate in an emergency situation. Findings include: During facility tour on 10/27/11, at 11:45 PM this surveyor and E1 (Maintenance Director) observed one light fixture with single bulb installed outside exit door from 400 wing (11:40	K 045			

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K 045	Continued From page 6 AM) and outside Main Dining room (11:45 AM). Interview with E1 at the time of observation confirmed the finding.	K 045			
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on the observation and interview, the facility failed to install and maintain fire alarm system in accordance with NFPA 101, 2000 Edition, Sections 19.3.4 and 9.6 as well as NFPA	K 051			

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K 051	Continued From page 7 72, 1999 Edition. This deficient practice could affect all residents as well as indeterminate number of staff and visitors. Findings include: During the facility tour on 10/27/11 at 1:30 PM, while accompanied by E1 (Maintenance Director) it was observed that facility's magnetic door hold open devices installed at smoke barrier doors returned to energized state when facility's fire alarm was silenced.	K 051		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, facility failed to provide complete testing and maintenance of the installed smoke detectors in accordance with NFPA 101, 2000 Edition, Section 9.6.1.3. This deficient practice could affect 60 of 121 residents, as well as indeterminate number of staff and visitors if smoke detector failed to operate properly due to sensitivity being outside of the designated range, or other problems undetected due to lack of testing and inspection. Findings include:	K 054		

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 054	Continued From page 8 During the facility tour on 10/27/11, this surveyor, E1 (Maintenance Director) observed hardwired smoke detectors installed within airflow of the HVAC ceiling diffuser (minimum distance is 36 inches) at following locations: 1. In Therapy room, installed 10 inches from the diffuser. 12:00 PM 2. In corridor adjacent to "Town Square" Kitchen, installed 18 inches from diffuser. 12:30 PM Interview with E1 at the time of observations confirmed the findings.	K 054			
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler coverage in accordance with NFPA 101, 2000 Edition, Section 9.7, 19.3.5 as well as NFPA 13. This deficient practice	K 056			

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND RENAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
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K 056	Continued From page 9 could affect 10 of 121 residents if fire were to spread due to insufficient sprinkler coverage. Findings include: During the tour of the facility on 10/27/11 at 1:00 PM this surveyor and E1 (Maintenance Director) observed sprinkler heads in closets of resident rooms 210, 212, 213, 214 and 215 obstructed by top of built in closets. Openings that allow sprinkler heads to cover built in closets were not cut in these rooms as there were in the rest of the facility. Interview with E1 at the time of observation confirmed the finding.	K 056			
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the general heating ventilation and air condition system (HVAC) was installed in accordance with NFPA 101, 2000 Edition, section 19.5.2.1, 19.5.2.2, and NFPA 90A, 1999 Edition. This deficient practice could affect 90 of 121 residents in this building, as well as an indeterminable number of staff and visitors. Findings include:	K 067			

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 178 THOMAS COURT WAUCONDA, IL 60084	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 10 During facility tour on 10/27/11 at 12:20 PM, while accompanied by E1 (Maintenance Director) observations determined that supply air for HVAC system was ducted to the exit access corridor. Return air grills were observed in corridors however there were no supply or return air grills in resident rooms. Resident rooms were heated with baseboard heaters. Toilet rooms inside resident sleeping rooms are equipped with exhaust air grills ducted to central rooftop exhaust fan units. This condition was observed in: 100 wing (12:20 PM), 300 wing (12:40 PM) and in resident rooms 202 to 215 in 200 wing (12:55 PM).	K 067		
K 144 SS=F	Interview with E1 at the time of observations and record review confirmed the findings. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on, record review and interview, the facility failed to provide proper testing for the emergency generator in accordance with the NFPA 101, 2000 Edition, Section 9.1.3, NFPA 99, 3.4.4.1, NFPA 110, 8.4.2. This deficient practice	K 144		

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K 144	Continued From page 11 could affect all residents in this building, as well as an indeterminable number of staff and visitors. Findings include: During the review of emergency generator maintenance records on 10/27/11 at 10:30 AM this surveyor and E1 (Maintenance Director) noted that facility is not recording transfer time from normal to emergency power during monthly generator exercise.	K 144			
K 147 S9=D	Interview with E1 at the time of record review confirmed the findings. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on the observation and interview, the facility failed to install electrical wiring in accordance with NFPA 101, 2000 Edition, Section 9.1.2 and NFPA 70, 1999 Edition, National Electrical Code. This deficient practice could affect 2 of 121 residents as well as an indeterminable number of staff in this smoke zone if improper electrical wiring causing electrocution or an electrical fire. Finding include: During the facility tour on 10/27/11, this surveyor, E1 (Maintenance Director) observed feeding pump plugged into power strip in resident room 116 at time of the survey. 12:10 PM	K 147			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 12	K 147			
K 154 SS=C	<p>Interview with E1 at the time of observations confirmed the findings.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on the review of policies and interview, the facility failed to establish a complete written policy indicating the procedures the facility must initiate when a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all the parties left unprotected by the shutdown until the sprinkler system has been returned to service in accordance with NFPA 101, 2000 Edition, Section 9.7.6.1. This deficient practice could affect all residents, as well as an indeterminable number of staff and visitors, if staff did not initiate the proper procedures when the sprinkler system was inoperable.</p> <p>Finding include: On 10/27/11 at 9:30 AM during the review of the</p>	K 154			

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084	
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K 154	Continued From page 13 facility policies, this surveyor and E1 (Maintenance Director) noted that facility's Fire Watch policy indicates that fire watch is to be instituted in case sprinkler system is out of service for period of more than four hours instead of more than four hours in 24 hour period.	K 154		
K 155 SS=C	Interview with E1 during the review of policies confirmed the finding. NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on the review of policies and interview, the facility failed to establish a complete written policy indicating the procedures the facility must initiate when a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all the parties left unprotected by the shutdown until the fire alarm system has been returned to service in accordance with NFPA 101, 2000 Edition, Section 9.7.6.1. This deficient practice could affect all residents, as well as an indeterminable number of staff and visitors, if staff did not initiate the proper procedures when the fire alarm system was	K 155		

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K 155	Continued From page 14 inoperable. Finding include: On 10/27/11 at 9:30 AM during the review of the facility policies, this surveyor and E1 (Maintenance Director) noted that facility's Fire Watch policy indicates that fire watch is to be instituted in case sprinkler system is out of service for period of more than four hours instead of more than four hours in 24 hour period. Interview with E1 during the review of policies confirmed the finding.	K 155			
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 211			

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	<p>Continued From page 15</p> <p>failed to properly install Alcohol Based Hand Rub dispensers in accordance with 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623. This deficient practice could affect 30 of 121 residents as well as an indeterminable number of staff if fire incident were to occur due to improper location of ABHR dispensers.</p> <p>Findings include:</p> <p>Based on observations during facility tour on 10/27/11 this surveyor and E1 (Maintenance Director) observed alcohol based hand rub dispenser installed directly above electrical outlet in "Town Square" kitchen. 1:20 PM</p> <p>Interview with E1 at the time of observation confirmed the findings</p>	K 211		

**COMPLIANCE REPORT FOR SKILLED NURSING, INTERMEDIATE CARE
AND OTHER 24-HOUR FACILITIES (Civil Rights Act Title VI)**

If any of the questions below require an explanation, use PART IV REMARKS and identifying comments by Item Number.

I. IDENTIFYING INFORMATION

Wauconda Healthcare + Rehab 176 Thomas Ct Wauconda, IL 60084
Name of Facility Street Address City, County, State and Zip code

MEDICARE PROVIDER NO. 145887 847-526-5551
Telephone Number (include area code)

MEDICAID PROVIDER NO. 0044859

Bed Capacity
Licensed Bed Capacity 135 Medicare Beds Approved 135
Medicaid Beds Approved 87 Current Bed Capacity ~~135~~ 135

Name, Address and Telephone Number of Owner of Facility

- TYPE OF FACILITY
- Skilled Nursing Facility
 - Intermediate Care Facility
 - Intermediate Care Facility for the Mentally Retarded
 - Mental Health Facility
 - Other (Specify)

- TYPE OF CONTROL
- Religious
 - Fraternal
 - Other non-profit
 - County
 - Proprietary
 - Other (Specify)
Corporation

II. RESIDENT ADMISSION AND DISTRIBUTION

Does your facility have a written policy of nondiscrimination that provides for resident admission and service without regard to race, color, or national origin? Yes No

Is this policy displayed in areas of the facility accessible to employees, residents, and the public? Yes No

Describe briefly any amendments to your civil rights policy or any implementation efforts made since the last compliance report. (Use PART IV REMARKS) NA

Has the community been notified of your policy to accept residents and render services without regard to race, color or national origin? Yes No

If "yes" is checked enter date and check method of communication: Public Relations
 Newspaper Radio Letter Other (Specify)

Is use of your facility limited to membership in a defined group? (i.e. fraternal organization, religious denomination, employees of a corporation, etc.) Yes No If "yes" explain and describe membership requirements. (Use PART IV REMARKS)

Estimate the number of residents of minority groups (African American, American Indian, Oriental and Hispanic) admitted during the last year
 0 1-10 11-20 21-50 over 50

Total number of minority group residents in today's census 3

II. RESIDENT ADMISSION AND DISTRIBUTION (continued)

Indicate below the number of minority group residents in today's census by type and room assignment according to the following breakdown:

Type of Room Assignment	African American	American Indian	Oriental	Hispanic
Number in single rooms or in room alone.	0	0	0	0
Number in semi-private or ward rooms having only minority persons.	0	0	0	0
Number in semi-private or ward rooms with one or more non-minority persons.	0	0	1	2
TOTAL	0	0	1	2

Indicate the number of residents in today's census whose charges made by your facility are paid in part or full by Medicare or Medicaid.

Type of Aid	Total	African American	American Indian	Oriental	Hispanic
Medicare	1	0	0	0	1
Medicaid	2	0	0	1	1

What is the approximate percentage of minority group population in the geographic service area from which most of your residents are drawn? 22% %

III. SERVICE AND FACILITY UTILIZATION

Are all services and facilities used routinely by all persons without regard to race, color, or national origin? (i.e. nursing care, social services, occupational therapy, dining area, barber shop, beauty salons, etc.) Yes No
If "no" specify which are not.

Are services rendered in this facility without regard to race, color, or national origin of either the resident or the person rendering the service? Yes No If "no" specify which services are not.

Estimate below the number of physicians and other licensed paramedical personnel not on your payroll that gave resident service in this facility during the last month by race of the physician or person rendering the service.

Physicians and Other Non-Salaried Paramedical Personnel	Total	African American	American Indian	Oriental	Hispanic
	1	0	0	0	1

IV. REMARKS

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF (A willfully false statement is punishable by law: U.S. Code, Title 18, Sec. 1001).

Signature of Authorized Official <i>Margaret [Signature]</i>	Title <i>Administrator</i>	Date <i>10-24-11</i>
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ATTACHMENT LTC-29A

RESIDENT CENSUS AND CONDITION OF RESIDENTS

Provider No. 146887	Medicare F76	Medicaid F78	Other F77	Total Residents F78
	35	42	45	122

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 109	F81 13
Dressing	F82 0	F83 113	F84 9
Transferring	F85 0	F86 111	F87 11
Toilet Use	F88 1	F89 103	F80 8
Eating	F91 84	F92 24	F93 14

A. Bowel/Bladder Status

F94 3 With indwelling or external catheter

F95 Of the total number of residents with catheters, 3 were present on admission.

F96 81 Occasionally or frequently incontinent of bladder

F97 81 Occasionally or frequently incontinent of bowel

F98 17 On individually written bladder training program

F99 17 On individually written bowel training program

B. Mobility

F100 1 Bedfast all or most of time

F101 32 In chair all or most of time

F102 6 Independently ambulatory

F103 101 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of total number of residents restrained, 0 were admitted with orders for restraints.

F106 6 With contractures

F107 Of the total number of residents with contractures, 6 had contractures on admission.

C. Mental Status

F108 0 With mental retardation

F109 66 With documented signs and symptoms of depression

F110 1 With documented psychiatric diagnosis (exclude dementias and depression)

F111 36 Dementia: multi-infarct, senil, Alzheimer's type, or other than Alzheimer's type

F112 26 With behavioral symptoms

F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 0

F114 0 Receiving health rehabilitative services for MI/MR

D. Skin Integrity

F115 3 With pressure sores (excluding Stage 1)

F116 Of the total number of residents with pressure sores excluding Stage 1, how many residents had pressure sores on admission?
3

F117 122 Receiving preventive skin care

F118 0 With rashes

Resident Census and Conditions of Residents

E. Special Care

<p>F119 <u>8</u> Receiving hospice care benefit</p> <p>F120 <u>0</u> Receiving radiation therapy</p> <p>F121 <u>0</u> Receiving chemotherapy</p> <p>F122 <u>0</u> Receiving dialysis</p> <p>F123 <u>0</u> Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion</p> <p>F124 <u>16</u> Receiving respiratory treatment</p> <p>F125 <u>1</u> Receiving tracheostomy care</p> <p>F126 <u>2</u> Receiving ostomy care</p>	<p>F127 <u>4</u> Receiving suctioning</p> <p>F128 <u>21</u> Receiving injections (exclude vitamin B12 injections)</p> <p>F129 <u>11</u> Receiving tube feedings</p> <p>F130 <u>28</u> Receiving mechanically altered diets including pureed and all chopped food (not only meat)</p> <p>F131 <u>40</u> Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)</p> <p>F132 <u>22</u> Assistive devices while eating</p>
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F. Medications

<p>F133 <u>91</u> Receiving any psychoactive medication</p> <p>F134 <u>22</u> Receiving antipsychotic medications</p> <p>F135 <u>29</u> Receiving antianxiety medications</p> <p>F136 <u>58</u> Receiving antidepressant medications</p> <p>F137 <u>13</u> Receiving hypnotic medications</p> <p>F138 <u>13</u> Receiving antibiotics</p> <p>F139 <u>62</u> On pain management program</p>	
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G. Other

<p>F140 <u>8</u> With unplanned significant weight gain/loss</p> <p>F141 <u>9</u> Who do not communicate in the dominant language of the facility (include those who use sign language)</p> <p>F142 <u>2</u> Who use non-oral communication devices</p> <p>F143 <u>116</u> With advanced directives</p> <p>F144 <u>80</u> Received influenza immunization</p> <p>F145 <u>88</u> Received pneumococcal vaccine</p>	
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I certify that this information is accurate to the best of my knowledge

Signature of Person Completing the Form	Title	Date
LEONOR SALVADOR 	RN	10/24/2011

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey?	_____ Yes	_____ No
F147 Was ombudsman present during any portion of the survey?	_____ Yes	_____ No
F148 Medication error rate _____ %		

CMS Certification Number (CCN): 145887

March 1, 2012
(By Certified Mail and Facsimile)

Margaret Ryan, Administrator
Wauconda Healthcare and Rehabilitation
176 Thomas Court
Wauconda, IL 60084

Dear Ms. Ryan:

SUBJECT: DISPOSITION OF REMEDIES
Cycle Start Date: October 27, 2011

PRIOR NOTICE

On December 22, 2011, we informed you that we were imposing remedies due to the failure of your facility to be in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs.

SUBSEQUENT VISITS AND SUMMARY OF ENFORCEMENT REMEDIES

On January 27, 2012, the Illinois Department of Public Health (IDPH) conducted a Life Safety Code (LSC) revisit at your facility, which revealed continued non-compliance. This survey found the most serious deficiency at scope and severity (S/S) level F, cited as follows:

- K40 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The IDPH advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567). In response to your continued noncompliance, the IDPH recommended that the Centers for Medicare & Medicaid Services (CMS) continue the previously imposed remedies.

The IDPH conducted in-office reviews of documentation you submitted to verify compliance on February 1, 2012, and found that your facility was in substantial compliance as of December 30, 2011. As a result of these survey findings, and in consideration of the results of the Informal Dispute Resolution you requested, the final status of remedies is as follows:

- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be imposed effective January 27, 2012, is rescinded as of December 30, 2011. We are notifying National Government Services and the Illinois Department of Healthcare and Family Services of the rescission of the denial of payment remedy. Thus, there should be no interruption in payment for covered services
- Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective April 27, 2012, will not be imposed

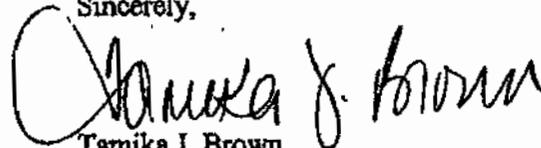
NURSE AIDE TRAINING PROHIBITION

In our formal notice dated December 22, 2011, we advised you that, in accordance with Section 1819(f)(2)(B)(iii)(I)(b) of the Social Security Act, your facility is prohibited from conducting a Nurse Aide Training and/or Competency Evaluation Program for two years from January 27, 2012 due to denial of payment for new Medicare and Medicaid admissions. Since your facility attained substantial compliance on December 30, 2011, the original triggering remedy did not go into effect. Therefore, the NATCEP prohibition is rescinded.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Certification Specialist, at (312) 353-5169 or me, at (312) 353-1502. Information may also be faxed to (443) 380-6614. All correspondence should be directed to me in our Chicago office.

Sincerely,



Tamika J. Brown
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

cc: Illinois Department of Public Health
Illinois Department of Healthcare and Family Services
National Government Services
Illinois Department on Aging
Telligen

RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item document a timetable with milestone dates of major activities to correct the deficiency that can be monitored on any follow up visit. (If additional space is required, use additional page)

PROVISION NUMBER	PROVIDER JUSTIFICATION FOR REQUESTING TEMPORARY WAIVER				
<p>K94</p> <p>K-067</p> <p>NAME OF FACILITY: <u>WALTONDA N.F.H.</u></p> <p>PROVIDER #: <u>145887</u></p> <p>TEMPORARY WAIVER EXPIRATION DATE: <u>AUG. 31, 2012</u></p>	<p>Violation: K 067</p> <p>Completion Date: August 31, 2012</p> <p>Project Scope:</p> <ol style="list-style-type: none"> 1. The K067 deficiency identified the 100 and 300 corridors as using the corridor as a plenum. 2. Part of the 200 wing will also need ductwork modifications. (see attached floor plan for corridor locations) 3. We will use the existing roof top units if design and engineering will allow. 4. Existing corridor ceilings – plaster – will need to be removed 5. Ductwork will be modified distributing make up air directly into the room 6. New ATC ceilings will be re-installed. 7. The building is a Type 2(000). 8. One corridor will be completed at one time in 3 different phases. <p>(see continuation sheet)</p>				
<p>FIRE AUTHORITY OFFICIAL</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="text-align: center;">RECOMMEND WAIVER</td> </tr> <tr> <td style="width: 15%;"></td> <td style="text-align: center;">DO NOT RECOMMEND WAIVER</td> </tr> </table> <p><small>(Initials)</small></p>		RECOMMEND WAIVER		DO NOT RECOMMEND WAIVER	
	RECOMMEND WAIVER				
	DO NOT RECOMMEND WAIVER				
<p>SURVEYOR RECOMMENDATIONS ATTACHED</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Provider Representative Signature: _____ Date: _____</p>				
<p>Fire Authority Official Signature: _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Title</td> <td style="width: 25%;">Office</td> <td style="width: 50%;">Date</td> </tr> </table>	Title	Office	Date	
Title	Office	Date			

January 24, 2012

Facility: Wauconda Healthcare and Rehab. Center
176 Thomas Court
Wauconda, IL 60084

Building 01 – Main Building

Provider No.: 145887

NFPA 101 – 2000 Edition

Continuation Sheet – Temporary Waiver Request

Violation: K 067

Completion Date: August 31, 2012

Milestones:

1. Design & engineering to be completed by February 24, 2012. This is required due to the identification of the same deficiency in the 200 corridor.
2. Submission to IDPH by on February 24, 2012.
3. Bidding and project letting by March 30, 2012
4. IDPH review and approval process completed by April 20, 2012. (estimate only)
5. Corridor 100 completion date – May 31, 2012
6. Corridor 200 completion date – June 30, 2012
7. Corridor 300 completion date – July 31, 2012
8. Test & balance of all 3 corridors – August 10, 2012
9. Project certification package to IDPH – August 10, 2012.
10. IDPH field review and certification – August 31, 2012 (estimate only)

Interim Measures:

1. This is an existing condition. Maintenance staff will be in-serviced to shut down subject exhaust fans and the RTU's servicing these corridors upon fire alarm activation to limit the transfer of smoke.
2. Residents will be relocated from all construction areas. Construction will take place during convenient hours for the residents.
3. Additional fire drills will be conducted each month to in-service staff as to proper evacuation procedures during an emergency.
4. Additional fire drills will be conducted each month on additional procedures for evacuation during any ongoing construction.
5. Policies and procedures will be updated.

Responsible party for correction & monitoring: **Administrator**

Rooms (1999 Edition, NFPA 13, Section 5-13.6) that are the responsibility of the facility to understand and comply with, that may result in costly upgrades that will require time to complete. Since there is no waiver and/or FSES provision after August 13, 2013, it is imperative that you ensure that your facility is fully sprinkled in accordance with the regulation on August 13, 2013. Failure to do so is likely to result in enforcement remedies, including but not limited to termination.

If you have any questions concerning this notice, please contact my staff at the address above or telephone (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,

Acting Division Chief
Division of Life Safety and Construction
Illinois Department of Public Health

Enclosure(s)

cc: State Medicaid Agency
Illinois Department on Aging
Lawrence Schwartz, Registered Agent
File (3)

LR1/0108/aw/LK

ATTACHMENT LTC-29A

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26864, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 145887	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 1/27/2012
Name of Facility WAUCONDA HEALTHCARE AND REHAB	Street Address, City, State, Zip Code 176 THOMAS COURT WAUCONDA, IL 60084	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 12/30/2011	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 12/30/2011	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/> State Agency	Reviewed By <i>WLM</i>	Date: 1/30/12	Signature of Surveyor: <i>Robert Barnett</i>	Date: 01/27/12
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 12/15/2011		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/27/2012
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K8 PLAN APPROVAL: 1966, 2002 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF Type of Structure: One story, Type II (000), 1966, unprotected noncombustible construction with a partial basement and a 2002 addition of the same construction type. The facility has complete coverage by an automatic (wet) sprinkler system with an antifreeze loop protecting the front entry overhang. The facility has a total of eight smoke compartments. A MF-1 to a Comparative Federal Monitoring Survey was conducted on 12/15/11, following a State Agency Annual Survey on 10/27/11 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Wauconda Healthcare & Rehabilitation Centre was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	{K 000}			
{K 040} SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5	{K 040}		12/30/11	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 01/27/2012
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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 178 THOMAS COURT WAUCONDA, IL 60084
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 040}	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exit access doors with the minimum clear width of 32 inches. The deficient practice affected one of eight smoke compartments, ten staff and no residents. The facility has the capacity for 135 beds with a census of 121 the day of survey. Findings include: Observation on 12/15/11 at 10:45 a.m. revealed that one of the two exit access doors from the basement area was obstructed by dryer vent ductwork only allowing the door to open to approximately 18 to 24 inches in width. Interview on 12/15/11 at 10:45 a.m. with the Maintenance Supervisor revealed that the facility was aware that the exit access door did not meet the minimum required clear width of 32 inches as a result of the state agency survey. The census of 121 was verified by the Administrator on 12/15/11. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/15/11. Actual NFPA Standard: NFPA 101, 7.2.1.1.1. A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door. Actual NFPA Standard: NFPA 101, 7.2.1.2.3. Door openings in means of egress shall be not	{K 040}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 01/27/2012
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 040}	Continued From page 2 less than 32 in. (81 cm) in clear width. Where a pair of doors is provided, one of the doors shall provide not less than a 32-in. (81-cm) clear width opening.	{K 040}		
{K 067} SS=E	Temporary Waiver to Expire 01/31/12 NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of egress corridors as a return air plenums and to provide a balanced engineered return air supply system. The deficient practice affected two of eight smoke compartments, staff and 34 residents. The facility has the capacity for 135 beds with a census of 121 the day of survey. Findings Include: 1. Observation on 12/15/11 at 11:15 a.m. revealed that the facility was using the area below the gypsum board ceiling structure in the egress corridor of the 100 Hall as a return air plenum with supply registers in the resident rooms and the return registers located below the gypsum board ceiling structure in the corridors only. The return registers were drawing air from the resident rooms through the egress corridor space	{K 067}		8/31/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146887	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/27/2012
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 067}	<p>Continued From page 3</p> <p>below the gypsum board ceiling structure. The facility was unable to provide evidence of a balanced engineered HVAC system without using the egress corridor space below the gypsum board ceiling structure for a return air supply plenum. Interview with the Maintenance Supervisor on 12/15/11 at 11:15 a.m. revealed that the facility was aware of the requirement that prohibits the use of egress corridors as return air plenums as a result of the state agency survey.</p> <p>2. Observation on 12/15/11 at 11:35 a.m. revealed that the facility was using the area below the gypsum board ceiling structure in the egress corridor of the 300 Hall as a return air plenum with supply registers in the resident rooms and the return registers located below the gypsum board ceiling structure in the corridors only. The return registers were drawing air from the resident rooms through the egress corridor space below the gypsum board ceiling structure. The facility was unable to provide evidence of a balanced engineered HVAC system without using the egress corridor space below the gypsum board ceiling structure for a return air supply plenum. Interview with the Maintenance Supervisor on 12/15/11 at 11:35 a.m. revealed that the facility was aware of the requirement that prohibits the use of egress corridors as return air plenums as a result of the state agency survey.</p> <p>The census of 121 was verified by the Administrator on 12/15/11. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 12/15/11.</p> <p>Actual NFPA Standard: NFPA 90A section</p>	{K 067}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146887	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 01/27/2012
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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 178 THOMAS COURT WAUCONDA, IL 60084
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(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
{K 067}	<p>Continued From page 4</p> <p>2-3.11.1*. Egress corridors in health care, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas.</p> <p>Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor.</p> <p>Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted.</p> <p>Exception No. 3: Use of egress corridors as part of an engineered smoke-control system.</p> <p>Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g., grating doors or grating partitions).</p> <p>Temporary Waiver to Expire 08/31/12</p>	{K 067}		

Temp. waiver 302



825-535 West Jefferson Street, Springfield, Illinois 62781-0001 • www.idph.state.il.us
February 2, 2012

Pat Quinn, Governor

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Ms. Margaret Ryan, Administrator
Wauconda Healthcare And Rehab
176 Thomas Court
Wauconda, IL 60084

Reference: Provider #:145887/0044859
Cycle Date: October 27, 2011
Survey Date: February 1, 2012
Survey Type: First revisit to Life Safety Code Survey
& Interim LSC Temporary Waiver Revisit of 2/1/2012 to LSC
Federal Monitoring Survey of 12/15/2011.
LSC Survey: October 27, 2011

Dear Ms. Ryan:

On October 27, 2011, an "Annual Inspection" was conducted at Wauconda Healthcare And Rehab by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare/Medicaid programs. As a result of that inspection and any required revisits, the Department is recommending to the Centers for Medicare and Medicaid Services and the Illinois Department of Healthcare & Family Services that the facility be certified for continuing participation in the Medicare (Title 18) and Medicaid (Title 19) programs.

It is recommended to the Centers for Medicare and Medicaid Services (CMS) that the Denial of Payment for New Admissions imposed in the notice dated December 21, 2011 be rescinded.

If you have any questions concerning this notice, please contact my staff at (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800 547-0466.

Sincerely,
Richard L. Dees
Richard L. Dees, Chief
Bureau of Long Term Care

cc: Centers for Medicare and Medicaid Services
Illinois Department of Healthcare & Family Services
Illinois Department on Aging
Mr. Lawrence Schwartz, Registered Agent
File 2

F1/LJK

ATTACHMENT LTC-29A



Pat Quinn, Governor

626-635 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

November 28, 2011

Ms. Margaret Ryan, Administrator
Wauconda Healthcare And Rehab
176 Thomas Court
Wauconda, IL 60084

REFERENCE:	Provider #:	145887/0044859
	Cycle Date:	October 27, 2011
	Survey Date:	October 27, 2011
	Survey Type:	Health Survey
	LSC Survey	October 27, 2011

Dear Ms. Ryan:

On October 27, 2011, an inspection was conducted at Wauconda Healthcare And Rehab by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare/Medicaid programs. As a result of that inspection, deficiencies were written for which an acceptable Plan of Correction (POC) is required. This letter is to document that an acceptable POC has been received by the Department.

If you have any questions, please contact my staff at (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,

Richard L. Dees, Chief
Bureau of Long-Term Care

cc: File 2
DO:/ LJK

ATTACHMENT LTC-29A

Improving public health, one community at a time

printed on recycled paper

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH) Docket No. NH 11-S0386
STATE OF ILLINOIS,)
Complainant,)
)
vs.)
)
WAUCONDA HEALTHCARE & REHABILITATION)
CENTRE, LLC,)
Respondent,)

NOTICE OF TYPE "B" VIOLATION(S);
NOTICE OF FINE ASSESSMENT;
NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101) (Act);
NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois (Department) that there has been a substantial failure by Respondent to comply with the Act. This determination is subsequent to an Annual Licensure Investigation conducted by the Department on October 27, 2011 at Wauconda Healthcare & Rehab, 176 Thomas Court, Wauconda, Illinois. On November 30, 2011, the Department determined that such violations constitute one or more Type B violations of the Act and the Skilled Nursing & Intermediate Care Facilities Code, 77 IL. Adm. Code 300. The nature of each such violation is further described in the CMS 2567 which is attached hereto as Attachment A and made a part hereof.

Pursuant to Section 3-303(b) of the Act, the licensee shall, within (10) days of the delivery to the licensee of this Notice of Violation, prepare and submit to the Department a plan of correction for all Type "B" violations and any violations listed under the Administrative Warning heading for which a plan of correction is required. The plan of correction shall be filed with the Illinois Department of Public Health, Division of Long-Term Care Quality Assurance, 525 West Jefferson, Springfield, Illinois 62761. The plan should include a correction date not to exceed sixty (60) days for Administrative Warning violations for which a plan of correction is required, and thirty (30) days for Type "B" violations, a description of how the violation was or is to be corrected, and a statement describing what measures will be taken to avoid reoccurrence of the violation. If the Department for any reason rejects the submitted plan of correction, a notice of the rejection and the reason for the rejection will be forwarded to the facility representative.

A modified plan shall be filed within ten (10) days of receipt of the notice of rejection. If the modified plan is not timely submitted, or if the modified plan is rejected, the Department will impose a plan of correction.

Pursuant to Section 3-303(c) of the Act you may submit a report of correction in place of a plan of correction for any of the violations which have already been corrected. The report of correction shall contain the correction date, a description of how the violation was corrected and statement describing what

ATTACHMENT LTC - 29A

measures will be taken to avoid reoccurrence of the violation. The report of correction must be signed by the administrator under oath.

A "Type B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Nursing Home Care Act.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of \$1,100.00, as follows:

Type B Violation for violating one or more of sections 300.1210b)2), 300.1210d)5) and 300.3240a), a fine of \$1,100.00.

Section 3-310 of the Act provides that all penalties shall be paid to the Department within thirty (30) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

ATTACHMENT LTC-29A

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "B" Violation(s), Notice of Conditional License, and Notice of Fine Assessment. In order to obtain a hearing the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices. The request for hearing must be sent to the Illinois Department of Public Health, Division of Long-Term Care, Quality Assurance, 525 West Jefferson Street, Fifth Floor, Springfield, Illinois 62761.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-305(10), 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine, or in exchange for an offset of any civil money penalty paid for a federal deficiency equivalent to the violation(s) upon which the fine is based. The amount of the offset cannot exceed 75% of the fine.

Licensees wishing to receive the automatic 35% waiver reduction must submit a written waiver of the right to a hearing, along with a check for 65% of the fine. Licensees wishing to receive an offset for the amount of any civil money penalty paid must submit a written waiver of the right to a hearing, and either proof of the federal civil money paid or a copy of a letter to the Centers for Medicare and Medicaid Services (CMS) of its binding intent to waive its right to a federal hearing to contest the civil money penalty. Waiver materials and payments must be submitted within ten (10) business days of receipt of this notice to the address above for requesting a hearing. For a licensee submitting a binding letter to CMS waiving its right to a federal hearing, the fine shall be due within ten (10) business days of when the facility receives notice from CMS of the amount of the civil money penalty it will owe. Please note that, in accordance with 77 IL. Adm. Code 300.282(k), the determination of what constitutes an equivalent federal deficiency will be determined by the Department.



Toni Colón
Deputy Director
Office of Health Care Regulation

Dated this 7th day of December, 2011.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH)
STATE OF ILLINOIS)
Complainant,)

Docket No. NH 11-S0386

vs.)

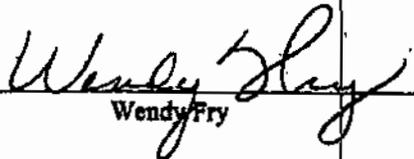
WAUCONDA HEALTHCARE & REHABILITATION,)
CENTRE, LLC,)
Respondent,)

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type B Violation(s) and Order to Abate or Eliminate; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent: Lawrence Y. Schwartz
Licensee Info: Wauconda Healthcare & Rehabilitation Centre, LLC.
Address: 8170 N. McCormick Blvd, STE 219
Skokie, Illinois 60076

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 8th day of DECEMBER 2011.


Wendy Fry

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2011
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 15</p> <p>300.1210b)2) 300.1210d)5) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p>	F9999			

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F0999	<p>Continued From page 18</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observations, interview and record review the facility failed to address a resident's poor positioning and failed to identify a rash resulting from the resident's poor position. The facility failed to assess, provide interventions, and care plan to prevent limitations in range of motion to the neck. These failures resulted in 1 resident (R15) developing a neck rash with fungus and severe range of motion limitation of the neck. The sample size is 24.</p> <p>The findings include:</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff</p>	F0999			

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F9999	<p>Continued From page 17</p> <p>for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:06 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM and 10:55 AM.</p> <p>On 10/26/11 at 10:55 AM E6 (Restorative Aide) said that R15 usually keeps her head down and her eyes closed. E6 lifted up R15's head slightly and held it. A deep red rash was noted in the skin folds of R15's neck. E3 (Restorative and Wound Nurse) was present at this time. E3 said that she was not aware that R15 had a rash on her neck.</p> <p>On 10/26/11 at 11:10 AM Z1 (Doctor) examined R15's neck. Z1 said that R15 had a rash with fungus. Z1 said that he ordered anti-fungal cream.</p> <p>On 12/26/11 at 12:36 PM E7 (CNA) said that she noticed that R15 had a rash on her neck in the morning but did not tell the nurse because she thought the nurse new about it.</p> <p>On 12/26/11 at 11:20 AM E8 (Nurse) said that she was not aware that R15 had a rash on her neck.</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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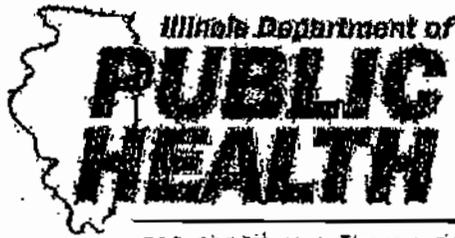
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F9999	<p>Continued From page 18</p> <p>most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 has bilateral functional limitations in range of motion of the upper extremity (shoulder, elbow, wrist, hand), and lower extremity (hip, knee, ankle, foot) according to the 9/14/11 MDS. The facility's Restorative Functional Assessment dated 9/14/11 does not assess R15's limited range of motion of her neck. Physical Therapy notes dated 1/5 - 1/12/11 document that R15 needs reminders to keep her head up and sit upright. R15's therapy discharge recommendations for restorative care dated 2/3/11 state "Encourage pts head position to be up." R15's Care Assessment Areas dated 3/18/11 does not assess R15's behavior of holding her head down. R15's care plan does not identify R15's behavior of holding her head down, and no interventions were planned.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM, 10:55 AM and 2:25 PM.</p> <p>On 10/26/11 E3 (Restorative Nurse) said that there was no prior assessment of R15's range of motion to her neck. E3 said that the restorative functional assessment does not include a section for evaluating range of motion to the neck. On 10/27/11 at 12:10 PM E3 said that R15 did not have a care plan addressing R15's behavior of holding her head down and no interventions were planned.</p>	F9999			

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F9999	Continued From page 19 On 10/26/11 at 1:50 PM E6 (Restorative Aide) said that R15 has been holding her head down more in the past 3 - 5 months. E6 said that R15 could previously holding her head up on her own, but now she cannot hold it on her own. E6 said "sometimes I turn her head" because she won't do it on her own. On 10/17/11 at 8:55 AM Z2 (Physical Therapist Assistant) said that when R15 was admitted in March of 2010 she did not have any neck issues according to the therapy notes. Z2 said that R15 was picked up by therapy again in January 2011 after she had a fall. Z2 said that at that time they noticed that R15 was starting to put her head down and needed cues to hold her head up and stand upright. Z2 said that no range of motion measurements were taken of R15's neck because range of motion wasn't a problem. Z2 pointed out that when R15 was discharged from therapy on 2/3/11 it was recommended that staff encourage R15 to hold her head up. On 10/27/11 Z3 (Physical Therapist) completed an assessment on R15. Z3 said that R15 cannot hold her head up on her own. Z3 said that R15 has severe limits to range of motion upon left rotation of the head. Additionally, Z3 said that R15 has functional limits to range of motion to all areas of her neck. Z3 said that R15 requires proper positioning/body alignment to reduce further reductions in range of motion. (B)	F9999			



Pat Quinn, Governor

526-585 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

November 9, 2011

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Ms. Margaret Ryan, Administrator
Wauconda Healthcare & Rehab
176 Thomas Court
Wauconda, Illinois 60084

RE: Provider #:145887/0044859
Survey Date: October 27, 2011
Survey Type: Annual Health Survey

Dear Ms. Ryan:

Pursuant to the Illinois Nursing Home Care Act, a licensure survey was conducted at Wauconda Healthcare & Rehab on October 27, 2011 by staff of the Illinois Department of Public Health. The licensure survey was part of a combined survey during which federal certification regulations were also evaluated. As a result of that combined survey, certification deficiencies have been issued to the facility and certification remedies have been proposed, recommended or imposed.

Enclosed with this letter are licensure findings written as a result of that combined survey. Based on these findings, the Department may issue licensing violations to the facility which may result in a monetary fine, conditional license or other serious licensure penalty. If you wish, you may submit comments to the findings. Comments may be used by the facility to refute the findings of the surveyors, explain extenuating circumstances that the facility could not have reasonably prevented or inform the Department of methods and timetables to correct the non-compliance. After a review of the findings, and any comments timely submitted by the facility, the Department will determine whether to issue any licensure violations and licensure penalties.

Any such licensure violations and penalties shall be in addition to any certification deficiencies and remedies already received by the facility.

Improving public health, one community at a time

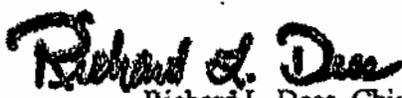
printed on recycled paper

ATTACHMENT LTC-29A

After you have reviewed the findings, please sign them and return them and any comments to the Illinois Department of Public Health, Division of Quality Assurance, Attention: Wendy Fry, 525 West Jefferson Street, Springfield, Illinois 62761. Comments must be received by the Department within 10 days of receipt of the findings by the facility.

If you have any questions concerning these findings please contact, at (217) 782-5180 or you may contact the department's TTY number (hearing impaired use only) at 1-800-547-0466.

Sincerely,


Richard L. Dees, Chief
Bureau of Long-Term Care

Enclosures
cc: Reviewer
File 2
LIC/FINDINGS/LJK

ATTACHMENT LTC-29A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 14 Findings include: 1) During the initial tour with E3(restorative/treatment nurse) on 10/24/2011 at 10:45 A.M., E4 (housekeeper) was changing bed linens in room 104-1. E4 placed set of clean linens and blanket on top of an open drawer next to the bed of 104-2. E4 stated that she will use the set of clean linens for beds 1 and 2 in room 104. 2) On 10/24/2011 at 10:50 A.M., E4 (housekeeper) was changing linens in 111-2. E4 was using linens/blanket that was on top of bed in 111-1. 3) On 10/24/2011 at 11:00 A.M., E5 (housekeeper), carried multiple sets of linens and blanket by holding these lines next to her upper body and arms. E4 brought all these set of clean linens and placed on top of bed in room 306-1. E5 proceeded to change linens in 306-2 and was using the linens that was placed on top of bed 1. E5 stated that she will also use some of the linens in another room (302). Review of the facility's policy for linen handling showed to carry linens away from body, should not touch the body, carry linens into a resident room one set per bed at a time and that linens should not be stored in the resident's drawers for any reason.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE FINDINGS 300.1210a)	F9999		

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F9999	Continued From page 15 300.1210b)2) 300.1210d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	F9999			

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F9999	<p>Continued From page 16</p> <p>2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p>	F9999			

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F9999	<p>Continued From page 17</p> <p>Based on observations, interview and record review the facility failed to address a resident's poor positioning and failed to identify a rash resulting from the resident's poor position. The facility failed to assess, provide interventions, and care plan to prevent limitations in range of motion to the neck. These failures resulted in 1 resident (R15) developing a neck rash with fungus and severe range of motion limitation of the neck. The sample size is 24.</p> <p>The findings include:</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM and 10:55 AM.</p> <p>On 10/26/11 at 10:55 AM E6 (Restorative Aide) said that R15 usually keeps her head down and her eyes closed. E6 lifted up R15's head slightly and held it. A deep red rash was noted in the skin folds of R15's neck. E3 (Restorative and Wound Nurse) was present at this time. E3 said that she was not aware that R15 had a rash on her neck.</p>	F9999		

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NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 18</p> <p>On 10/26/11 at 11:10 AM Z1 (Doctor) examined R15's neck. Z1 said that R15 had a rash with fungus. Z1 said that he ordered anti-fungal cream.</p> <p>On 12/26/11 at 12:38 PM E7 (CNA) said that she noticed that R15 had a rash on her neck in the morning but did not tell the nurse because she thought the nurse new about it.</p> <p>On 12/26/11 at 11:20 AM E8 (Nurse) said that she was not aware that R15 had a rash on her neck.</p> <p>R15 is an 81 year old, severely cognitively impaired resident who was re-admitted to the facility on 3/15/10 with multiple diagnoses, including Parkinson's Disease, according to the most recent Minimum Data Assessment (MDS) dated 9/14/11. R15 is totally dependent on staff for bed mobility, transfers, locomotion, dressing, eating and personal hygiene, according to the 9/14/11 MDS. R15 has bilateral functional limitations in range of motion of the upper extremity (shoulder, elbow, wrist, hand), and lower extremity (hip, knee, ankle, foot) according to the 9/14/11 MDS. The facility's Restorative Functional Assessment dated 9/14/11 does not assess R15's limited range of motion of her neck. Physical Therapy notes dated 1/5 - 1/12/11 document that R15 needs reminders to keep her head up and sit upright. R15's therapy discharge recommendations for restorative care dated 2/3/11 state "Encourage pts head position to be up." R15's Care Assessment Areas dated 3/18/11 does not assess R15's behavior of holding her head down. R15's care plan does not</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2011
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 178 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 19</p> <p>identify R15's behavior of holding her head down, and no interventions were planned.</p> <p>R15 was observed in her wheelchair with her head down and her chin touching the right side of her upper chest on 10/24/11 at 2:10 PM; 10/25/11 at 8:45 AM, 9:10 AM, 11:00 AM, 12:55 PM and 4:05 PM; and 10/26/11 at 8:45 AM, 10:05 AM, 10:20 AM, 10:41 AM, 10:55 AM and 2:25 PM.</p> <p>On 10/26/11 E3 (Restorative Nurse) said that there was no prior assessment of R15's range of motion to her neck. E3 said that the restorative functional assessment does not include a section for evaluating range of motion to the neck. On 10/27/11 at 12:10 PM E3 said that R15 did not have a care plan addressing R15's behavior of holding her head down and no interventions were planned.</p> <p>On 10/26/11 at 1:50 PM E6 (Restorative Aide) said that R15 has been holding her head down more in the past 3 - 5 months. E6 said that R15 could previously holding her head up on her own, but now she cannot hold it on her own. E6 said "sometimes I turn her head" because she won't do it on her own.</p> <p>On 10/17/11 at 8:55 AM Z2 (Physical Therapist Assistant) said that when R15 was admitted in March of 2010 she did not have any neck issues according to the therapy notes. Z2 said that R15 was picked up by therapy again in January 2011 after she had a fall. Z2 said that at that time they noticed that R15 was starting to put her head down and needed cues to hold her head up and stand upright. Z2 said that no range of motion measurements were taken of R15's neck.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2011
NAME OF PROVIDER OR SUPPLIER WAUCONDA HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 176 THOMAS COURT WAUCONDA, IL 60084		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	Continued From page 20 because range of motion wasn't a problem. Z2 pointed out that when R15 was discharged from therapy on 2/3/11 it was recommended that staff encourage R15 to hold her head up. On 10/27/11 Z3 (Physical Therapist) completed an assessment on R15. Z3 said that R15 cannot hold her head up on her own. Z3 said that R15 has severe limits to range of motion upon left rotation of the head. Additionally, Z3 said that R15 has functional limits to range of motion to all areas of her neck. Z3 said that R15 requires proper positioning/body alignment to reduce further reductions in range of motion.	F9999			

License
Application



625-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

June 28, 2011

License ID: 0044859
Facility ID: 6009435
Region: 7

Administrator
Wauconda Healthcare and Rehab
176 Thomas Court
Wauconda, IL 60084

Dear Administrator:

A 1993 amendment to the Nursing Home Care Act allows the Department to issue two year licenses to qualifying Long-Term Care facilities.

A review of your facility's inspection history reveals that this facility meets the criteria outlined in Section 3-110 of the Act. As a result, your upcoming license will be issued for a period of two years, expiring **11/30/2013**, pursuant to meeting the criteria in Section 3-110b of the Act. An inspection, survey, or evaluation can change your qualification for the issuance of a two year license. An inspection will be performed prior to the expiration date of your current license to determine if the facility still meets the two year license criteria.

The application form for the renewal of your facility's license is attached. Your qualified status as a two year recipient results in an application fee of **\$3,980.00**. Please submit this payment in the form of a check or money order, made payable to the Department of Public Health.

It is your facility's responsibility to notify the Department of any changes made within the ownership structure of the legal entity designated as your facility's Operator/Licensee and Owner of Site and Building which occur at any time before your next renewal period.

If you have any questions regarding this correspondence, please contact the Licensure Section at 217/782-5180, or for the hearing impaired, the Department's TTY number is 1-800/547-0466.

Sincerely,

Richard L. Dees, Chief
Bureau of Long Term Care
Quality Assurance



Illinois Department of

PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

June 28, 2011

License ID: 0044869
Facility ID: 6009436
Region: 7

Administrator
Wauconda Healthcare and Rehab
176 Thomas Court
Wauconda, IL 60084

Dear Administrator:

Your facility's current license is due for renewal on **11/30/2011**. Your upcoming license will be effective **12/01/2011** and will expire on **11/30/2013**. Before we can issue the renewal license, an application must be on file and considered complete by this Department. The package of information is included with this letter as well as a return envelope. The package includes:

- **Application for Long Term Care Facility License** (2 copies enclosed) ✓

This document reflects the information contained in our data system. Please review the information, make any changes or revisions. A facility representative must sign, date, and have a notary complete the appropriate section upon returning the **ORIGINAL**. Any changes in information for corporations, limited liability companies, limited partnerships, general partnerships, or trusts need to be accompanied by the appropriate documents supporting the change. Your facility is also required to submit a license application fee of **\$3,980.00** in the form of a check or money order payable to the Illinois Department of Public Health. The second original of the Application for Long Term Care Facility License should be retained by the facility.

- **Resident Room/Bed/Level of Care Listing** (2 copies enclosed) ✓

This form reflects the information currently on file with the Department. Please review the data provided, make any revision on this form. The last page must be signed and dated by a facility representative upon returning the **ORIGINAL**. A corresponding floor plan that identifies every resident room must be returned along with the enclosed form. If a preprinted form was not provided, a blank form with instructions is enclosed. **Relocation of previously disclosed rooms/beds must be accompanied by an executed statement indicating that all licensure requirements have been met, using the enclosed document entitled: RELOCATION OF LICENSED BEDS. This form must be signed and dated and returned even if no relocation has taken place.** Please retain the second original form for future reference.

Improving public health, one community at a time
printed on recycled paper

ATTACHMENT LTC-29A

- ****REVISED** Resident Fund Surety Bond** (facility provided) ✓

A copy of the Surety Bond currently in effect needs to be provided. This includes the Schedule A, all Riders and/or Endorsements. The Bond and Schedule A must be completed in their entirety. The resident Fund Disclosure Update Form is no longer required as part of the license renewal process.

- **Alzheimer's Special Care Disclosure Update** (2 copies enclosed) ✓

This form provides the information each facility must submit to meet the requirements of the Alzheimer's Special Care Disclosure Act. One of the choices must be checked in Part A of the form. If the second choice is checked, all 9 items must be submitted with each renewal application. **This ORIGINAL form must be signed, dated, and returned.** The second copy of the form is to be retained by the facility.

- **Long-Term Care Facility Administrator Form** (2 copies enclosed) ✓

This form provides the information necessary to verify the administrator license status and the name of the administrator currently employed at this facility. The current facility administrator and/or newly appointed administrator must complete the enclosed **ORIGINAL form and provide a copy of the current/active administrator license certificate.** The administrator and/or house manager form has now been included as part of the facility license renewal process; requiring submission on forms provided by the department. All facilities are required to report any change in administrator to the Department within five (5) days. Please retain the second original form for future reference.

Our complete **ORIGINAL** application package is to be submitted at least 120 days prior to your current license expiration date. Using the return envelope provided with this package will ensure prompt receipt and processing.

Any deviation from the information contained in the attached application package must be promptly disclosed to the Department within 10 days of the change, pursuant to the Nursing Home Care Act (210 ILCS) Section 3-207(a). Issuance of a license does not negate the facility's obligation to notify the Department, in writing, of any changes contained in the application package, including, but not limited to, the ownership structure of the legal entity designated as Operator/Licensee and Owner of Site and Building prior to the next renewal period.

If you have any questions concerning this correspondence or submission of your application package, contact the Licensure Section at 1-217/782-5180 or for the hearing impaired the Department's TTY number is 1-800/547-0466.

Sincerely,

Richard L. Dees

Richard L. Dees, Chief
Bureau of Long Term Care
Quality Assurance

ATTACHMENT LTC-29A



300 N. State Street Suite 4104 Chicago IL 60610
P. 312.802.2401 F. 312.923.9177
2401inc@speedsite.com

Reference: Wauconda Healthcare – Facility Expansion & Partial Renovation

IDPH Provider Number – 145887

Existing Facility Review:

The current existing facility is 39,953 SF. It is a one story building with a partial basement.

Condition is excellent and meets all the requirements of NFPA 101, 2000 edition and all applicable local and state codes.

Thank you for your time in reviewing this.

Sincerely,

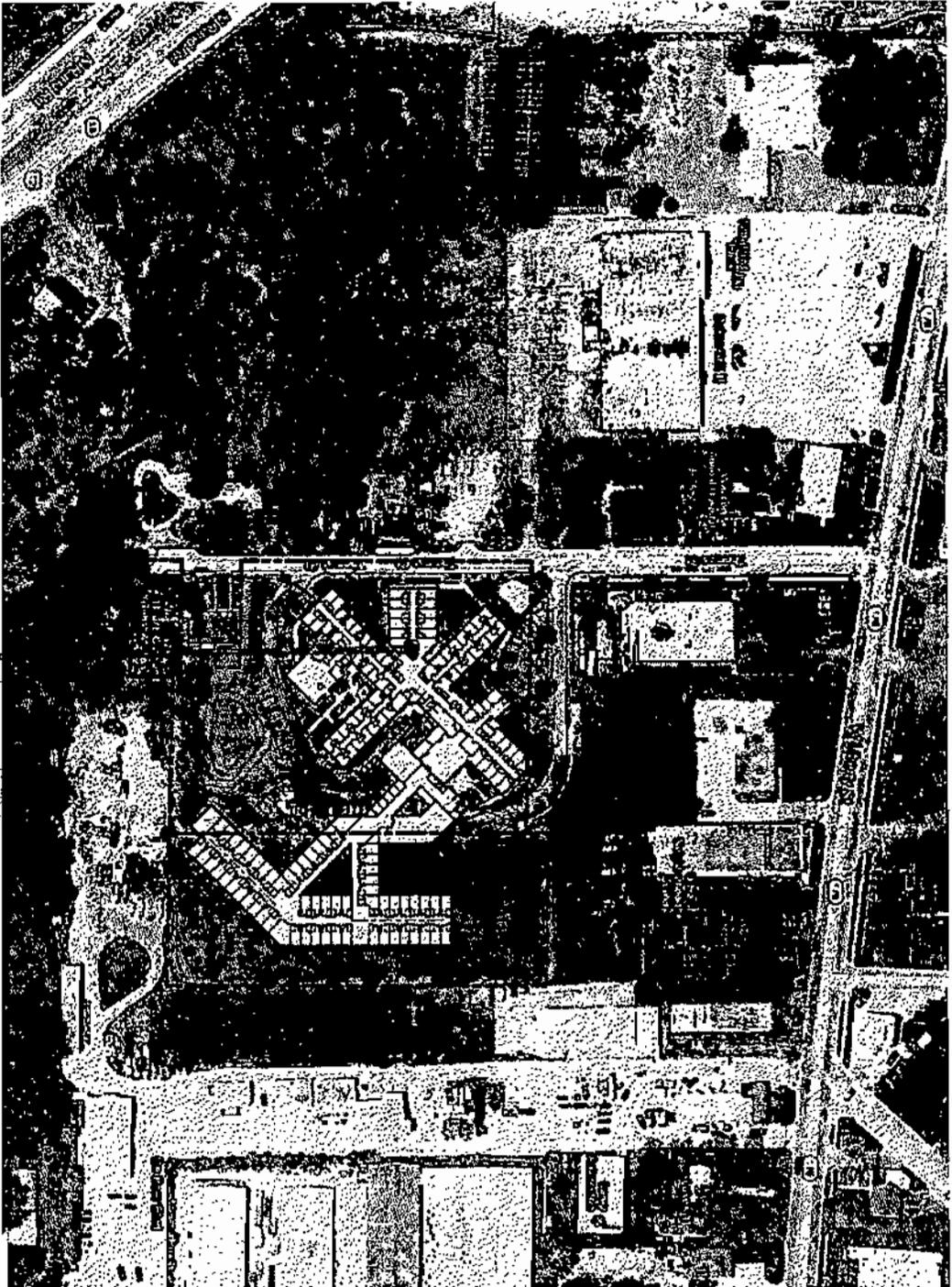
A handwritten signature in black ink, appearing to read 'R L Kane', with a horizontal line extending to the right.

Randal L. Kane, Architect
2401 Incorporated

ATTACHMENT LTC-29B

300 N State Street #4104 Chicago Illinois 60610
P. 312.802.2401 F. 312.923.9177 2401inc@speedsite.com

2401
ALCOHOL
ED
AGRICULTURAL CONSULTANTS



EXISTING FACILITY

ALCOHOL AGRI CONSULTANTS

Christopher Vicere

From: Laura Zung [laura@zung.org]
Sent: Thursday, May 03, 2012 10:45 AM
To: Christopher Vicere
Subject: Age of Wauconda

The original Wauconda building was finished in 1966.
In 1994, the 400 Wing was added and the dining room was enlarged.
In 2005, The Town Square and Alzheimer's Unit were added.

Margaret is sending me the survey and life safety docs. I will forward them to you.

Lz



CONFIRMATION OF RECEIPT OF IDPH LTC QUESTIONNAIRE

Information for 2011 from your LTC facility has been received by the Illinois Health Facilities and Services Review Board.

Thank you for your cooperation.

Please print out a copy of this confirmation notice for your records.

February 29, 2012

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011

This survey has been customized for your facility based on information in the IDPH databases.
Please verify the information on this page.

Facility Information

Facility Name

WAUCONDA HEALTHCARE CENTER

Facility Address

176 THOMAS COURT

Facility City

WAUCONDA , IL

Facility Zip Code

60084

Licensed Beds <Definitions>

135

Licensed Beds shown here for information. Do not change.

Page 3 of 15

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part I - Facility and Utilization Data

Please read the instructions for each question for clarification to understand the nature of the necessary response. All numeric fields are pre-filled with zeroes. As appropriate, complete all questions with required data. Validation rules are included to assist you in entering accurate and consistent data throughout the Questionnaire. All row and columns asking for entry of a total value are compared to the sum of the row and/or column. If entered values do not conform to the validation rules, please verify and enter the correct values.

Question 1 - Is your facility designated as any of the following:

Use this link to access definitions: [Definitions](#)

- Life Care Facility
 Continuing Care Retirement Community

Question 2 - Indicate conditions that prevent admission to your facility. Check all that apply. At least one box must be checked. Please note that if None (No Restrictions) is checked, no other boxes should be checked. [Definitions](#)

- | | |
|--|---|
| <input checked="" type="checkbox"/> Aggressive/Anti-Social | <input type="checkbox"/> Non-Mobile |
| <input type="checkbox"/> Chronic Alcoholism | <input checked="" type="checkbox"/> Other Government Recipient* |
| <input checked="" type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Under 65 Years of Age |
| <input checked="" type="checkbox"/> Drug Addiction | <input type="checkbox"/> Unable to Self-Medicates |
| <input type="checkbox"/> Medicaid Recipient | <input checked="" type="checkbox"/> Ventilator Dependency |
| <input type="checkbox"/> Medicare Recipient | <input type="checkbox"/> Infectious Disease Requiring Isolation |
| <input checked="" type="checkbox"/> Mental Illness | <input type="checkbox"/> Other Restrictions |
| <input type="checkbox"/> Non-Ambulatory | <input type="checkbox"/> None (No Restrictions) |

* 'Other Government Recipient' includes individuals whose primary source of payment is Veterans

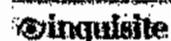
Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, or other government-sponsored programs.

Question 3 - If your facility ownership requires a Registered Agent with the Illinois Secretary of State, indicate the name, address and telephone number of this person or company (must be an Illinois resident or company).

Name of Registered Agent:
Address of Registered Agent
City, State and Zip Code (plus
Four):
Telephone Number:

Christopher Vicere
5061 N. Pulaski
Chicago, IL 60031
773-604-4416

Page 4 of 15



ATTACHMENT LTC-29C

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part I - Facility and Utilization Data

Question 4 - Please report the number of Full-Time Equivalent Employees (FTEs), paid directly by your facility. DO NOT report the number of hours worked. Use the first pay period in December 2011 to account for your employees.

Due to the broad range of services provided in LTC facilities, IDPH is leaving the definition of 'Other Healthcare Personnel' broad enough to include all categories of healthcare staff not covered in the six listed major categories of personnel.

EMPLOYMENT CATEGORIES	FULL TIME EQUIVALENTS (FTEs)
Administrators	1
Physicians	0
Director of Nursing	1
Registered Nurses	15
LPNs	6
Certified Aides	69
Other Health Personnel	39
Other Non-Health Personnel	0
Totals 131	131

Please indicate the number of hours in the work week for a full-time employee:

**Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part I - Facility and Utilization Data**

Question 5 - Resident Information for 2011

Beds	1. Nursing Care	2. Sheltered	3. Total
1. Licensed Beds - 12/31/2011	135	0	135
2. Peak Beds Set Up - 2011*	135	0	135
3. Peak Beds Occupied - 2011*	135	0	135
4. Beds Set Up - 12/31/2011	135	0	135
5. Beds Occupied - 12/31/2011	122	0	122

* PEAK BEDS SET UP is the highest number of beds setup and staffed for use at any time during the year.
 PEAK BEDS OCCUPIED is the highest number of beds in use at any time during the year.
 AVAILABLE BEDS will be calculated as "Licensed Beds less Beds Occupied on December 31, 2011" [20 ILCS 3960/13]

Males

6. Under 18	0	0	0
7. 18 - 44	0	0	0
8. 45 - 59	0	0	0
9. 60 - 64	2	0	2
10. 65 - 74	8	0	8
11. 75 - 84	7	0	7
12. 85 & Over	11	0	11
13. Total Males	26	0	26

Females

14. Under 18	0	0	0
15. 18 - 44	0	0	0
16. 45 - 59	2	0	2
17. 60 - 64	0	0	0
18. 65 - 74	7	0	7
19. 75 - 84	29	0	29
20. 85 & Over	58	0	58
21. Total Females	96	0	96
22. Total Residents	122	0	122

	1. Nursing Care	2. Sheltered	3. Total
Patient Days for 2011	<i>Patient day values should be based on resident count for CALENDAR YEAR 2011.</i>		
23. Medicare Patient Days	11610	n/a	11610
24. Medicaid Patient Days	18237	n/a	18237
25. Other Public Pay Patient Days	0	0	0
26. Private Insurance Patient Days	1370	0	1370

27. Private Pay Patient Days	12976	0	12976
28. Charity Care* Patient Days	0	0	0
29. Total All Patient Days	44193	0	44193

Room Rates

30. Private Room Rate	0	0	n/a
31. Shared Room Rate	245	0	n/a

Racial Group Each resident in your facility on the last day of the year should be accounted for and counted only once.

32. Asian	2	0	2
33. Amer. Indian/Nat. Alaskan	0	0	0
34. Black/African American	0	0	0
35. Hawaiian/Pacific Islander	0	0	0
36. White	120	0	120
37. Race Unknown	0	0	0
38. Total All Races	122	0	122

Ethnicity Each resident in your facility on the last day of the year should be accounted for and counted only once.

39. Hispanic or Latino	1	0	1
40. Not Hispanic or Latino	121	0	121
41. Ethnicity Unknown	0	0	0
42. Total All Ethnicity	122	0	122

Primary Payment Source*	1. Nursing Care	2. Sheltered	3. Total
43. Medicare	39	n/a	39
44. Medicaid	44	n/a	44
45. Other Public	0	0	0
46. Private Insurance	1	0	1
47. Private Pay	38	0	38
48. Charity Care	0	0	0
49. Total Residents	122	0	122

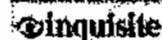
OTHER PUBLIC includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

PRIVATE PAY includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

INSURANCE refers to payment made through private insurance policies.

Charity care means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3060, Section 3] Charity care does not include bed debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

< Back Next > Save



**Illinois Health Facilities and Services Review Board (IDPH)
Long-Term Care Facility Questionnaire for 2011
Part I - Facility and Utilization Data**

Question 6 - Admissions and Discharges during the Calendar Year 2011.

Short-Term discharges to the hospital for Acute or Sub-Acute Care or releases to visit friends and relatives by residents who are expected to return to the facility are not to be counted as discharges or re-admissions. Count only those residents initially admitted and those permanently discharged from your facility. A resident who has been permanently discharged and later re-enters the facility may be counted as a new admission.

The sum of Lines A + B, minus Line C must equal Line D. The total number of residents recorded on Line D MUST NOT EXCEED the total number of licensed beds your facility has reported on Line 1 of QUESTION III. The total residents reported on line D must equal the total residents reported in Question IV and Question III, Lines 20a, 33, 37 and 44.

A. Residents on the FIRST DAY of the 2011.

Indicate the number of residents in your facility at the BEGINNING of the day on January 1, 2011 on Line A. The resident count should be the same as the resident count your facility reported to the Department on December 31, 2010.

125

B. Total Admissions DURING Calendar Year 2011.

Indicate the total number of residents your facility admitted during 2011 on Line B.

342

C. Total Discharges DURING Calendar Year 2011.

Indicate the total number of residents your facility discharged during 2011 on Line C. Remember, this value is final discharges only, not administrative discharges of any type.

345

D. Residents on the LAST DAY of 2011.

Indicate the total number of residents your facility had on December 31, 2011.

122

< Back Next > Save

Inquire

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part I - Facility and Utilization Data

Question 7 - Primary Diagnosis of Residents on DECEMBER 31, 2011.

Report the number of residents in your facility at the END OF THE LAST DAY OF 2011 by their PRIMARY diagnosis. COUNT ALL RESIDENTS - COUNT EACH RESIDENT ONLY ONCE. The primary diagnosis of a resident is the MAJOR health problem for which a resident is receiving care. Alongside each diagnostic group is the range of International Classification of Diseases codes contained within the particular diagnostic group. Use only the classifications listed - if a diagnosis does not fit into a listed classification include it in OTHER MEDICAL CONDITIONS.

NOTE: ALZHEIMER'S DISEASE - For the purpose of this questionnaire only - ALL RESIDENTS with a PRIMARY diagnosis of ALZHEIMER'S DISEASE are to be placed in the ICD-9 CODE 290.1 & 331.0.

ICD-9 CM Numbers	Primary Diagnosis	Number of Residents
140-239	Neoplasms	2
240-279	Endocrine/Metabolic Disorders	9
280-289	Blood Disorders	0
290.1 & 331.0	Alzheimer's Disease (All with Primary Diagnosis of Alzheimer's)	29
293-297,300	Mental Illness (Does not include Alzheimer's Disease)	0
299,315-319	Developmental Disabilities (Does not include Alzheimer's Disease)	0
320-389	Nervous System Disorders (Does not include Alzheimer's Disease)	7
390-459	Circulatory System Disorders	35
460-519	Respiratory System Disorders	9
520-579	Digestive System Disorders	1
580-629	Genitourinary System Disorders	2
680-709	Skin Disorders	3
710-739	Musculo-Skeletal Disorders	18
800-999	Injuries and Poisonings	5
	Other Medical Conditions	2
	Non-Medical Conditions	0
	Total Residents	122

Question 8 - Residents on December 31, 2011, whose Diagnosis included Mental Illness.

Report the number of residents in your facility on December 31, 2011, whose diagnosis included Mental Illness (ICD-9 CODE 293-297,300). Include all the residents reported with Primary Diagnosis of Mental Illness in Question 7, and all residents with a diagnosis of Mental Illness in addition to their Primary Diagnosis.

Residents with Diagnosis of Mental Illness

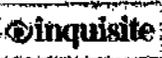
Question 9 - Residents on December 31, 2011, who were Identified Offenders*

Report the number of residents in your facility on December 31, 2011, who were categorized as "Identified Offenders".

Residents who were Identified Offenders

* Any resident so identified through a criminal history background check as required by the Nursing Home Care Act (210 ILCS 45/2-201.6) paragraphs b and c.

Click 'Next' to proceed to Part II - Financial and Capital Expenditures Data



ATTACHMENT LTC-29C

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part II - Financial & Capital Expenditures Data

**THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED
PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILCS 3960/5.3]**

**We have made fundamental changes in the way we are collecting the data, intended to
make responses easier and the data more accurate.**

**Part II - Financial and Capital Expenditures data for your facility MUST BE REPORTED
FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.
THESE DOLLAR AMOUNTS ARE FOUND IN YOUR MOST RECENT ANNUAL FINANCIAL
STATEMENTS WHICH INCLUDES YOUR INCOME STATEMENT STATEMENT AND
BALANCE SHEET.**

**FINANCIAL STATEMENTS ARE DEFINED AS AUDITED FINANCIAL STATEMENTS,
REVIEW OR COMPILATION FINANCIAL STATEMENTS, OR TAX RETURN FOR THE MOST
RECENT FISCAL YEAR AVAILABLE TO YOU.**

**If you have any problems providing the data requested, please contact this office by e-
mail at DPH.FacilitySurvey@Illinois.gov, or by telephone at 217-782-3516.**

Indicate the Starting and Ending Dates of your Fiscal Year (mm/dd/yyyy)

Starting **Ending**

Source of Financial Data Used



Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part II - Financial & Capital Expenditures Data

A. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures **IN EXCESS OF \$303,000** obligated by or on behalf of the health care facility for your reported Fiscal Year (click the link below the table for definitions of terms):

	Description of Project / Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if reviewed)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

[Definitions](#)

Report the **TOTAL** of ALL Capital Expenditures for your reported Fiscal Year
 (include expenditures below \$303,000):

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR
 (including those below \$303,000)

36,679.00

Illinois Health Facilities and Services Review Board (IHFSRB)
Long-Term Care Facility Questionnaire for 2011
Part II - Financial & Capital Expenditures Data

B. NET REVENUES BY PAYMENT SOURCE FOR YOUR REPORTED FISCAL YEAR

	Fiscal Year Net Revenues
Medicare	7054358
Medicaid	3036294
Other Public Pay*	0
Private Insurance*	404710
Private Payment*	2741603
TOTAL NET REVENUES FOR REPORTED FISCAL YEAR	13236965

* 'OTHER PUBLIC PAY' Includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

'PRIVATE INSURANCE' refers to payment made through private insurance policies.

'PRIVATE PAYMENT' Includes money from a private account AND any government funding

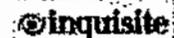
made out and paid to the resident which is then transferred to the facility to pay for services.

C. ACTUAL COST OF CHARITY CARE SERVICES PROVIDED IN YOUR REPORTED FISCAL YEAR

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960, Section 3)
 Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

	Amount
Actual Cost of Services Provided to Charity Care Residents in Reported Fiscal Year	0

 >



**Illinois Health Facilities and Services Review Board (IHFSRB)
 Long-Term Care Facility Questionnaire for 2011
 Part III - Influenza/Pneumonia Vaccinations**

The Immunization Section of the Illinois Department of Public Health requests that you provide the following information regarding the immunization policies and immunization status of your staff and residents in regards to Influenza and pneumococcal pneumonia.
 Thank you.

	Yes	No
Does your facility have a written policy for administering Influenza vaccine to RESIDENTS?	<input checked="" type="radio"/>	<input type="radio"/>
Does your facility have a written policy for administering pneumococcal vaccine to RESIDENTS?	<input checked="" type="radio"/>	<input type="radio"/>
Does your facility have a written policy for vaccinating STAFF MEMBERS against influenza?	<input checked="" type="radio"/>	<input type="radio"/>
Does your facility have a written policy for vaccinating STAFF MEMBERS against pneumococcal pneumonia?	<input type="radio"/>	<input checked="" type="radio"/>
Does your facility have a written policy for use of amantadine and/or rimantadine during an influenza outbreak?	<input type="radio"/>	<input checked="" type="radio"/>

	Number Receiving Influenza Vaccine	Number NOT Receiving Influenza Vaccine
Record the number of RESIDENTS who received Influenza vaccine during the time period from October, 2011 through January, 2012	45	10

	Number Receiving Pneumococcal Vaccine	Number NOT Receiving Pneumococcal Vaccine
Record the number of CURRENT RESIDENTS who have received a pneumococcal vaccine in the years 2006 through 2011	96	18

Inquisite

**Illinois Health Facilities and Services Review Board (IHFSRB)
 Long-Term Care Facility Questionnaire for 2011
 Part IV - Older Adult Services Survey**

The Older Adult Services Advisory Committee, created by Public Act 093-1031, is required to gather information about services being provided to older adults in the State of Illinois as part of its mandate to "promote a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services".

1. What outpatient or community based services to clients, other than your nursing home residents, does your facility or affiliated agency offer?

Outpatient/Community-Based Services.	Average Daily Number of Clients Served in the Previous Month	
Outpatient Physical Therapy		
Outpatient Occupational Therapy		
Outpatient Speech Therapy		
In House Respite Care Program 24 Hours or More	0	
In House Respite Care Program Less than 24 Hours Per Day		
Adult Day Care Services Not Part of Respite Care Program		
Alzheimer's Adult Day Care Services Not Part of Respite Care Program		
Home Health Care for Medicare or Medicaid Clients		
Home Care Services for Private Pay Clients		
Homemakers and Personal Care Assistants		
Home Delivered Meals Program		
Transportation Services for Persons in the Community		
Outpatient Wound Care and/or Specialized Wound Care		
Outpatient Dialysis		
Community Family Caregiver Training or Support*		
Community Nutrition Site		
Outpatient Telephone Reassurance for Community Seniors		
Private Duty Nursing Services		

* For Community Members Other than Residents' Family Members

2. What Other Outpatient/Community Services Does Your Facility Offer?

Illinois Health Facilities and Services Review Board (IHFSB)
Long-Term Care Facility Questionnaire for 2011

Please provide the following contact information for the individual responsible for the preparation of this questionnaire:

Contact Person Name	MARGARET RYAN
Contact Person Job Title	ADMINISTRATOR
Contact Person Telephone	847-526-5551
Contact Person E-Mail Address	mryan@lancastr-hg.com

Please provide the following information for the Facility Administrator/CEO of the facility:

Administrator's Name	MARGARET RYAN
Administrator's Title	ADMINISTRATOR
Administrator Telephone	847-526-5551
Administrator E-Mail Address	mryan@lancastr-hg.com

THANK YOU FOR COMPLETING THE ON-LINE LONG-TERM CARE QUESTIONNAIRE.
 If you have any comments on the survey, please enter them in the space below.



Illinois Health Facilities and Services Review Board (IHFRSB)
Long-Term Care Facility Questionnaire for 2011

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILCS 3960/13), the State Board requires "all health facilities operating in the State to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. By completing this section, the named individual is certifying that he/she has read the foregoing document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentations will be considered material.

I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying	<input type="text" value="Margaret Ryan"/>		
Job Title	<input type="text" value="Administrator"/>	Certification Date	<input type="text" value="02/29/2012"/>

WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.

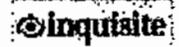
ONCE YOU HAVE SUBMITTED THE FORM, NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.

YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM. SO BE SURE TO VERIFY YOUR ANSWERS BEFORE CLICKING ON THE 'SUBMIT FORM' BUTTON.

WHEN YOU HAVE REVIEWED AND PRINTED YOUR RESPONSES, CLICK THE 'SUBMIT FORM' BUTTON TO SEND YOUR COMPLETED QUESTIONNAIRE BACK TO OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.

IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT 217-782-3516 OR BY EMAIL AT DPH.FACILITYSURVEY@ILLINOIS.GOV

< Back	Submit Form	Save
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CONFIRMATION OF RECEIPT OF ANNUAL LTC QUESTIONNAIRE

**Thank you for submitting your facility survey information.
Your information has been received by the Illinois Health Facilities and Services Review Board.**

If you would like to print out a dated confirmation receipt, [CLICK HERE](#)

J.P.Morgan

Amy Welzer
Managing Director
Private Banking

May 24, 2012

To Whom It May Concern:

J.P. Morgan has been the banker for Wauconda Healthcare and Rehabilitation Centre, LLC and the Lancaster Health Group for over 10 years. They have sufficient cash and securities in excess of \$10,000,000 to fund their commitment for the construction of the 57 bed addition to Wauconda. In addition, they will have sufficient cash and securities to fund three years of operations.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Amy Welzer

10 S. Dearborn, 8th floor, Chicago, IL 60603

Telephone: +1 312-732-3564 Facsimile: +1 312-732-7424 Email: amy_welzer@jpmorgan.com

J.P. Morgan Chase Bank, N.A.

ATTACHMENT-39

Bank products and services are offered through JPMorgan Chase Bank, N.A. and its affiliates. Securities are offered by J.P. Morgan Securities LLC



HealthCare & Rehabilitation Centre
Trusted care. Peace of mind.

May 7, 2012

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

RE: Criterion 1120.140.A Reasonableness of Financing Arrangements

Dear Ms. Avery:

Regarding the above referenced criterion, we hereby certify that the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Sincerely,

Christopher Vicere
Vice President - Finance

State of Illinois County of Cook

Sworn to before me this

7 day of MAY, 2012

Notary Public



ATTACHMENT-42A

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE
 Statements of Income and Expense - Projected
 For the Twelve Month Periods ended April 30, 2015 and 2016

	2015	Census 51,648	2016	Census 57,488
<u>Gross Income</u>	<u>\$15,466,366</u>	<u>\$299.46</u>	<u>\$17,904,566</u>	<u>\$311.45</u>
<u>Operating Expenses</u>				
Nursing	\$7,374,505	\$142.79	\$8,333,191	\$144.96
Housekeeping	535,457	10.37	605,067	10.53
Plant	331,913	6.43	375,061	6.52
Dietary	1,107,047	21.43	1,250,964	21.76
Employee Welfare	1,212,528	23.48	1,370,157	23.83
Laundry and Linen	153,541	2.97	173,501	3.02
<u>Total Operating Expenses</u>	<u>\$10,714,991</u>	<u>\$207.46</u>	<u>\$12,107,940</u>	<u>\$210.62</u>
<u>Income Before Gen and Admin Expenses</u>	<u>\$4,751,374</u>	<u>\$92.00</u>	<u>\$5,796,625</u>	<u>\$100.83</u>
<u>General and Administrative Expenses</u>	<u>\$1,477,899</u>	<u>\$28.62</u>	<u>\$1,670,025</u>	<u>\$29.05</u>
<u>Income Before Capital Expenses</u>	<u>\$3,273,476</u>	<u>\$63.38</u>	<u>\$4,126,600</u>	<u>\$71.78</u>
<u>Capital Expenses</u>				
Rent	\$1,881,048	\$36.42	\$1,937,479	\$33.70
Real Estate Taxes	187,714	3.63	193,346	3.36
Interest	5,351	0.10	5,511	0.10
Depreciation	24,211	0.47	25,988	0.45
<u>Total Capital Expenses</u>	<u>\$2,098,324</u>	<u>\$40.63</u>	<u>\$2,162,324</u>	<u>\$37.61</u>
<u>Net Income</u>	<u>\$1,175,152</u>	<u>\$22.75</u>	<u>\$1,964,276</u>	<u>\$34.17</u>

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE

Balance Sheet - Projected
30-Apr-15

ASSETS

Current Assets

Cash and Cash Equivalents	\$142,218
Accounts Receivable	4,026,861
Notes Receivable	1,441,291
Prepaid Expenses	22,498

Total Current Assets \$5,632,868

Property and Equipment

Leasehold Improvements	\$190,341
Furniture and Fixtures	606,350
Less: Accumulated Depreciation	685,956

Total Property and Equipment - Net \$110,735

Total Assets \$5,743,603

LIABILITIES AND STOCKHOLDERS' EQUITY

Current Liabilities

Accounts Payable	\$243,654
Accrued Liabilities:	
Payroll and Payroll Taxes	188,852
Expenses	174,876
Vacation and Sick Benefits	388,452
Real Estate and Sales Tax	196,306
Resident Trust Fund Liability	43,618
Bad Debt Reserve	85,259

Total Current Liabilities \$1,321,017

Stockholders' Equity

Retained Earnings Prior Years	\$3,247,434
Add: Net Income	1,175,152

Total Stockholders' Equity \$4,422,586

Total Liabilities and Stockholders' Equity \$5,743,603

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE

Balance Sheet - Projected

30-Apr-16

ASSETS

Current Assets

Cash and Cash Equivalents	\$174,890
Accounts Receivable	4,534,371
Notes Receivable	2,822,074
Prepaid Expenses	34,757

Total Current Assets \$7,566,092

Property and Equipment

Leasehold Improvements	\$211,818
Furniture and Fixtures	656,780
Less: Accumulated Depreciation	711,944

Total Property and Equipment - Net \$156,654

Total Assets \$7,722,746

LIABILITIES AND STOCKHOLDERS' EQUITY

Current Liabilities

Accounts Payable	\$264,155
Accrued Liabilities:	
Payroll and Payroll Taxes	204,301
Expenses	169,688
Vacation and Sick Benefits	374,605
Real Estate and Sales Tax	201,811
Resident Trust Fund Liability	46,512
Bad Debt Reserve	74,812

Total Current Liabilities \$1,335,884

Stockholders' Equity

Retained Earnings Prior Years	\$4,422,586
Add: Net Income	1,964,276

Total Stockholders' Equity \$6,386,862

Total Liabilities and Stockholders' Equity \$7,722,746

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE

Balance Sheet - Projected

30-Apr-17

ASSETS

Current Assets

Cash and Cash Equivalents	\$211,869
Accounts Receivable	5,144,001
Notes Receivable	4,593,404
Prepaid Expenses	39,707

Total Current Assets \$9,988,981

Property and Equipment

Leasehold Improvements	\$217,909
Furniture and Fixtures	674,446
Less: Accumulated Depreciation	741,808

Total Property and Equipment - Net \$150,547

Total Assets \$10,139,528

LIABILITIES AND STOCKHOLDERS' EQUITY

Current Liabilities

Accounts Payable	\$269,225
Accrued Liabilities:	
Payroll and Payroll Taxes	191,404
Expenses	167,799
Vacation and Sick Benefits	376,991
Real Estate and Sales Tax	204,155
Resident Trust Fund Liability	48,677
Bad Debt Reserve	94,852

Total Current Liabilities \$1,353,103

Stockholders' Equity

Retained Earnings Prior Years	\$6,386,862
Add: Net Income	2,399,563

Total Stockholders' Equity \$8,786,425

Total Liabilities and Stockholders' Equity \$10,139,528

WAUCONDA HEALTHCARE AND REHABILITATION CENTRE
Statements of Income and Expense - Projected
For the Twelve Month Periods ended April 30, 2015, 2016 and 2017

	2015	Census 51,648	2016	Census 57,488	2017	Census 57,488
<u>Gross Income</u>	<u>\$15,466,366</u>	<u>\$299.46</u>	<u>\$17,904,566</u>	<u>\$311.45</u>	<u>\$18,799,794</u>	<u>\$327.02</u>
<u>Operating Expenses</u>						
Nursing	\$7,374,505	\$142.79	\$8,333,191	\$144.96	\$8,583,186	\$149.31
Housekeeping	535,457	10.37	605,067	10.53	623,219	10.84
Plant	331,913	6.43	375,061	6.52	386,313	6.72
Dietary	1,107,047	21.43	1,250,964	21.76	1,288,492	22.41
Employee Welfare	1,212,528	23.48	1,370,157	23.83	1,411,262	24.55
Laundry and Linen	153,541	2.97	173,501	3.02	178,706	3.11
<u>Total Operating Expenses</u>	<u>\$10,714,991</u>	<u>\$207.46</u>	<u>\$12,107,940</u>	<u>\$210.62</u>	<u>\$12,471,178</u>	<u>\$216.94</u>
<u>Income Before Gen and Admin Expenses</u>	<u>\$4,751,374</u>	<u>\$92.00</u>	<u>\$5,796,625</u>	<u>\$100.83</u>	<u>\$6,328,615</u>	<u>\$110.09</u>
<u>General and Administrative Expenses</u>	<u>\$1,477,899</u>	<u>\$28.62</u>	<u>\$1,670,025</u>	<u>\$29.05</u>	<u>\$1,720,126</u>	<u>\$29.92</u>
<u>Income Before Capital Expenses</u>	<u>\$3,273,476</u>	<u>\$63.38</u>	<u>\$4,126,600</u>	<u>\$71.78</u>	<u>\$4,608,489</u>	<u>\$80.17</u>
<u>Capital Expenses</u>						
Rent	\$1,881,048	\$36.42	\$1,937,479	\$33.70	\$1,976,229	\$34.38
Real Estate Taxes	187,714	3.63	193,346	3.36	197,213	3.43
Interest	5,351	0.10	5,511	0.10	5,621	0.10
Depreciation	24,211	0.47	25,988	0.45	29,864	0.52
<u>Total Capital Expenses</u>	<u>\$2,098,324</u>	<u>\$40.63</u>	<u>\$2,162,324</u>	<u>\$37.61</u>	<u>\$2,208,927</u>	<u>\$38.42</u>
<u>Net Income</u>	<u>\$1,175,152</u>	<u>\$22.75</u>	<u>\$1,964,276</u>	<u>\$34.17</u>	<u>\$2,399,563</u>	<u>\$41.74</u>

Wauconda Healthcare and Rehabilitation Centre
Statements of Cash Flows - Projected
For the Twelve Month Periods Ended April 30, 2015, 2016 and 2017

<u>CASH FLOWS FROM OPERATING ACTIVITIES</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
Net Income	\$1,175,152	\$1,964,276	\$2,399,563
Add: Depreciation	24,211	25,988	29,864
ADJUSTED NET INCOME	\$1,199,363	\$1,990,264	\$2,429,427
Adjustments to Reconcile Adjusted Net Income to Net Cash Provided By Operating Activities:			
Increase in Accounts Receivable	(\$204,860)	(\$507,510)	(\$609,630)
Increase in Prepaid Expenses & Other Current Assets	(8,989)	(12,259)	(4,950)
Increase in Accounts Payable	10,876	20,501	5,070
Increase(Decrease) in Accrued Expenses and Other Current Liabilities	11,866	(5,634)	12,149
TOTAL ADJUSTMENTS	(\$191,107)	(\$504,902)	(\$597,361)
NET CASH PROVIDED BY OPERATING ACTIVITIES	\$1,008,256	\$1,485,362	\$1,832,066
<u>CASH FLOWS FROM INVESTING ACTIVITIES</u>			
Payments for Acquisition of Property and Equipment	(\$41,203)	(\$71,907)	(\$23,757)
<u>CASH FLOWS FROM FINANCING ACTIVITIES</u>			
Proceeds From Note Receivable - Related Parties	(\$865,664)	(\$1,380,783)	(\$1,771,330)
INCREASE IN CASH & CASH EQUIVALENTS	\$101,389	\$32,672	\$36,979
CASH AND CASH EQUIVALENTS - BEGINNING	40,829	142,218	174,890
CASH & CASH EQUIVALENTS - ENDING	\$142,218	\$174,890	\$211,869

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

Over the latest three year period, this facility has not reported any charity care:

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

Appended as **ATTACHMENT-44A** are copies of the "related entities'" annual IDPH facility profile that lists the total charity care expense and the charity care expense as a percent of total net revenue.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

This item is not germane as the facility is existing.

ATTACHMENT-44

ATTACHMENT-44