

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044859

Facility Name: Wauconda Healthcare and Rehabilitation Centre

Address: 176 Thomas Court Wauconda 60084
Number City Zip Code

County: Lake

Telephone Number: (847) 526-5551 Fax # (847) 526-0807

HFS ID Number:

Date of Initial License for Current Owners: 1st May 2000

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Christopher Vicere Telephone Number: (773) 604-4416
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2011 to 31-Dec-2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) 29th March, 2012
(Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid
Preparer

(Signed)
(Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Wauconda Healthcare and Rehabilitation Centre

0044859 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds None

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>135</u>	Skilled (SNF)	<u>135</u>	<u>49,275</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>135</u>	TOTALS	<u>135</u>	<u>49,275</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>461</u>	<u>585</u>	<u>12,769</u>	<u>13,815</u>	8
9	SNF/PED					9
10	ICF	<u>19,103</u>	<u>11,002</u>	<u>274</u>	<u>30,379</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,564</u>	<u>11,587</u>	<u>13,043</u>	<u>44,194</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.69%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1st May 2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1st May 2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 135 and days of care provided 11,697

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 31st Dec 2011 Fiscal Year: 31st Dec 2011

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

STATE OF ILLINOIS												
Facility Name & ID Number		Wauconda Healthcare and Rehabilitation Center				#	0044859	Report Period Beginning:		1-Jan-2011	Ending:	Page 3 31-Dec-2011
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)												
	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	326,199	29,357	265,462	621,018		621,018		621,018			1
2	Food Purchase		181,011		181,011	(20,177)	160,834	(765)	160,069			2
3	Housekeeping	266,793	65,147		331,940		331,940		331,940			3
4	Laundry	78,684	48,807		127,491		127,491		127,491			4
5	Heat and Other Utilities			213,334	213,334		213,334		213,334			5
6	Maintenance	66,970	73,164	115,737	255,871		255,871	(3,779)	252,092			6
7	Other (specify):*											7
8	TOTAL General Services	738,646	397,486	594,533	1,730,665	(20,177)	1,710,488	(4,544)	1,705,944			8
	B. Health Care and Programs											
9	Medical Director			26,400	26,400		26,400		26,400			9
10	Nursing and Medical Records	3,637,984	290,199	134,177	4,062,360		4,062,360		4,062,360			10
10a	Therapy		8,733	126,770	135,503		135,503		135,503			10a
11	Activities	49,810	29,539		79,349		79,349		79,349			11
12	Social Services	103,680		4,320	108,000		108,000		108,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,791,474	328,471	291,667	4,411,612		4,411,612		4,411,612			16
	C. General Administration											
17	Administrative	71,202		243,000	314,202		314,202	(42,401)	271,801			17
18	Directors Fees											18
19	Professional Services			58,439	58,439		58,439	12,395	70,834			19
20	Dues, Fees, Subscriptions & Promotions			37,448	37,448		37,448	(17,535)	19,913			20
21	Clerical & General Office Expenses	194,865	75,072	109,809	379,746		379,746	20,010	399,756			21
22	Employee Benefits & Payroll Taxes			833,366	833,366	20,177	853,543	5,992	859,535			22
23	Inservice Training & Education			3,116	3,116		3,116	18,358	21,474			23
24	Travel and Seminar			4,670	4,670		4,670	1,099	5,769			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,161	13,161		13,161		13,161			26
27	Other (specify):* *Payroll Taxes (Sch VII)							25,136	25,136			27
28	TOTAL General Administration	266,067	75,072	1,303,009	1,644,148	20,177	1,664,325	23,054	1,687,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,796,187	801,029	2,189,209	7,786,425		7,786,425	18,510	7,804,935			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			78,945	78,945		78,945	558,270	637,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							925,349	925,349			32
33	Real Estate Taxes			176,728	176,728		176,728		176,728			33
34	Rent-Facility & Grounds			1,241,865	1,241,865		1,241,865	(1,200,000)	41,865			34
35	Rent-Equipment & Vehicles			100	100		100		100			35
36	Other (specify):*											36
37	TOTAL Ownership			1,497,638	1,497,638		1,497,638	283,619	1,781,257			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		563,138	1,129,484	1,692,622		1,692,622		1,692,622			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,912	73,912		73,912		73,912			42
43	Other (specify):* *Addl.State Fee @\$6.07**			131,846	131,846		131,846		131,846			43
44	TOTAL Special Cost Centers		563,138	1,335,242	1,898,380		1,898,380		1,898,380			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,796,187	1,364,167	5,022,089	11,182,443		11,182,443	302,129	11,484,572			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,893	30		9
10	Interest and Other Investment Income	(3,571)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(765)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,261)	21		24
25	Fund Raising, Advertising and Promotional	(80,342)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A attached	(4,047)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,193)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	444,322	6,6A &6B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 444,322		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 302,129		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning: ID# 0044859

Ending: 1-Jan-2011

31-Dec-2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Deferred Maintenance Costs (expended in 2011)	\$ (7,249)	6	1
2	Deferred Maintenance Costs (to write off in 2011)	3,202	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,047)		49

Summary A

31-Dec-2011

[illegible]

Summary B

31-Dec-2011

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	\$	Lancaster, Ltd.	100.00%	\$ 10,995	\$ 10,995	1
2	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	102,271	102,271	2
3	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	5,992	5,992	3
4	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	1,099	1,099	4
5	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	102,648	102,648	5
6	V	20	Marketing Fees		Lancaster, Ltd.	100.00%	61,748	61,748	6
7	V	20	Dues, Fees & Subscriptions		Lancaster, Ltd.	100.00%	1,159	1,159	7
8	V	30	Depreciation		Lancaster, Ltd.	100.00%	6,145	6,145	8
9	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	268	268	9
10	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	18,358	18,358	10
11	V	32	Interest Paid		Lancaster, Ltd.	100.00%	3,157	3,157	11
12	V								12
13	V								13
14	Total			\$			\$ 313,840	\$ * 313,840	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fee Income	\$ 243,000	Lancaster, Ltd.	100.00%	\$	\$ (243,000)	15
16	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	97,951	97,951	16
17	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	4,342	4,342	17
18	V	27	Payroll Taxes-Staff		Lancaster, Ltd.	100.00%	20,794	20,794	18
19	V								19
20	V								20
21	V	32	**Direct Interest**		Lancaster, Ltd.		3,801	3,801	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 243,000			\$ 126,888	\$ * (116,112)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	\$ 1,200,000	Wauconda Associates		\$	\$ (1,200,000)	15
16	V	32	Interest	577	Wauconda Associates			(577)	16
17	V	32	Interest		Wauconda Associates		613,750	613,750	17
18	V	32	Mortgage Interest		Wauconda Associates		308,789	308,789	18
19	V	30	Depreciation		Wauconda Associates		523,232	523,232	19
20	V	19	Accounting Fees		Wauconda Associates		1,400	1,400	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,200,577			\$ 1,447,171	\$ * 246,594	39

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation Center # 0044859 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Christopher Vicere	VP-Finance	Administrative		see attached	10	20.83	Lancaster	\$ 38,559	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	10	20.83	Lancaster	59,392	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 97,951		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wauconda Healthcare and Rehabilitation Centre # 0044859 Report Period Beginning: 1-Jan-2011 Ending: -Dec-2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Lancaster, Ltd.
Street Address 5061 N. Pulaski Road
City / State / Zip Code Chicago, IL 60630
Phone Number (773)604-4416
Fax Number (773)478-1192

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Christopher Vicere	Hours Worked	48	4	\$ 185,082	\$ 185,082	10	\$ 38,559	1
2	27	Christopher Vicere-Payroll tax	Hours Worked	48	4	9,705		10	2,022	2
3	17	Cheryl Morris	Hours Worked	48	4	285,082	285,082	10	59,392	3
4	27	Cheryl Morris-Payroll tax	Hours Worked	48	4	11,135		10	2,320	4
5										5
6										6
7	19	Professional Services	Census Days	249,635	4	62,108		44,194	10,995	7
8	21	Clerical Expenses	Census Days	249,635	4	577,688	544,818	44,194	102,271	8
9	22	Employee Benefits	Census Days	249,635	4	33,844		44,194	5,992	9
10	24	Seminars and Travel	Census Days	249,635	4	6,209		44,194	1,099	10
11	17	Administrative Consulting	Census Days	249,635	4	579,818	579,818	44,194	102,648	11
12	20	Marketing Fees	Census Days	249,635	4	348,790	346,861	44,194	61,748	12
13	20	Dues, Fees and Subscriptions	Census Days	249,635	4	6,548		44,194	1,159	13
14	30	Depreciation	Census Days	249,635	4	34,708		44,194	6,145	14
15	6	Repairs and Maintenance	Census Days	249,635	4	1,513		44,194	268	15
16	23	Education and Inservice	Census Days	249,635	4	103,695		44,194	18,358	16
17	32	Interest	Census Days	249,635	4	17,830		44,194	3,157	17
18	27	Payroll Taxes	Census Days	249,635	4	117,455		44,194	20,794	18
19										19
20										20
21										21
22	32	**Direct Interest**							3,801	22
23										23
24										24
25	TOTALS					\$ 2,381,211	\$ 1,941,661		\$ 440,728	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle National Trust, N.A.		X	Mortgage	\$32,345.15	Feb 2009	\$ 3,595,000	\$ 3,387,420	Jan 2029	9.0000	\$ 308,789	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harston Investments		X	Working Capital							613,750	6
7	JP Morgan Chase Bank, Plc		X	Working Capital							3,157	7
8												8
9	TOTAL Facility Related				\$32,345.15		\$ 3,595,000	\$ 3,387,420			\$ 925,696	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,595,000	\$ 3,387,420			\$ 925,696	15

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

\$ None

Line #

N/A

Less: Interest Income

(347)

925,349

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	133,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	152,728	2
3. Under or (over) accrual (line 2 minus line 1).			\$	19,728	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	157,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	176,728	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	68,274	8	
		2007	135,430	9	
		2008	142,567	10	
		2009	127,001	11	
		2010	152,728	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Accrual is based on weighted average of last 4 year's taxes; adjusted for inflation					
** More weightage is placed on 2007 taxes due to new construction**					

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Wauconda Healthcare and Rehabilitation Centre</u>	COUNTY	<u>Lake</u>
---------------	--	--------	-------------

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604 - 4416 FAX #: (773) 478 - 1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.	<u>09-35-200-009</u>	<u>Long-Term Healthcare</u>		\$	<u>144,427.58</u>	\$	<u>144,427.58</u>
2.	<u>09-35-200-059</u>	<u>Long-Term Healthcare</u>		\$	<u>8,050.93</u>	\$	<u>8,050.93</u>
3.	<u>09-35-200-057</u>	<u>Long-Term Healthcare</u>		\$	<u>249.85</u>	\$	<u>249.85</u>
4.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
5.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
6.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
7.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
8.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
9.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
10.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
TOTALS				\$	<u><u>152,728.36</u></u>	\$	<u><u>152,728.36</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,038

B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: None 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	135		2000		\$ 7,131,000	\$ 428,690	39	\$ 380,777	\$ (47,913)	\$ 1,073,457	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Redwood Sign 4x6			2000	2,862	169	15	169		2,229	9
10	Nurses' Call System			2001	18,785		7			18,785	10
11	Fire Protection System			2001	99,420		7			99,420	11
12	Nurse Call Additions			2002	1,100		7	73	73	683	12
13	Construction of Dementia Unit			2006	2,288,579	58,678	40	114,429	55,751	638,895	13
14	Fittings & Fixtures to Dementia Unit			2006	130,960	7,543	5	10,913	3,370	130,960	14
15	Concrete Sidewalk			2006	7,050	439	15	470	31	2,624	15
16	Outside Landscaping			2006	19,800	1,234	15	1,320	86	7,370	16
17	New Brick Patio			2006	7,400	494	15	494		2,531	17
18	Dining Area Expansion, Nurses Station & Fitness Club			2007	196,512	5,039	39	9,826	4,787	44,217	18
19	Cabinetry & Lighting for above			2007	45,050	5,190	5	9,010	3,820	40,545	19
20	Renovation of Roof			2007	24,000		39	2,400	2,400	10,400	20
21	Preconstruction planning, Architectural & Auto CAD Work			2008	4,295	110	15	215	105	661	21
22	Demolition, Removal of Debris & Temporary Costruction			2008	3,500	89	15	175	86	542	22
23	Reconstruction of Dry Wall, Windows & Doors per Plan			2008	26,000	667	15	1,300	633	4,007	23
24	Installation of Suspended Ceiling & Electrical fitting/pipes			2008	5,000	128	15	250	122	770	24
25	Resurfacing of Parking Lot			2009	8,165	349	15	544	195	1,451	25
26	Fire Rated Door Frame & Fixtures			2009	1,870	48	10	187	139	452	26
27	Hot water heating Boiler			2009	11,500	295	10	1,150	855	2,683	27
28	Mirrored Walls, Windows & Tiles in Therapy Room			2009	16,748	429	10	1,675	1,246	4,606	28
29	4 Units of 120 Volts Electrical Panels in Nursing Stations			2010	12,500	321	10	1,250	929	1,563	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,062,096	\$ 509,912		\$ 536,627	\$ 26,715	\$ 2,088,851	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$363,606	\$43,921	\$69,832	\$25,911	7	\$215,762	71
72	Current Year Purchases	36,678	36,678	5,307	(31,371)	7	5,307	72
73	Fully Depreciated Assets	402,892	11,666	19,304	7,638	7	402,892	73
74	**Lancaster Allocation**		6,145	6,145			20,760	74
75	TOTALS	\$803,176	\$98,410	\$100,588	\$2,178		\$644,721	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,254,272	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$608,322	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$637,215	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$28,893	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,733,572	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wauconda Healthcare Associates ***a Related entity***
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	**Leased from a Related Entity**			\$			3
4	Additions							4
5	**Off-site Clerical Office**				39,615			5
6	***Off-site Vehicle Parking Space***				2,250			6
7	TOTAL				\$ 41,865			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A
- None
N/A

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 100 Description: Oxygen Concentrators @ \$50 each per month
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	None				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 493,848	\$		\$ 493,848	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			103,609			103,609	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			532,027			532,027	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-2	hrs				15,727		15,727	8
9	Pharmacy	39-2	# of prescrpts				487,781		487,781	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					39,391		39,391	12
13	Other (specify): **Speciality Beds**	39-2					20,239		20,239	13
14	TOTAL			\$		\$ 1,129,484	\$ 563,138		\$ 1,692,622	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 900	\$ 900	1
2	Cash-Patient Deposits	45,726	45,726	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,395,729	3,395,729	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,359	40,359	6
7	Other Prepaid Expenses	5,751	5,751	7
8	Accounts Receivable (owners or related parties)	886,163	1,038,980	8
9	Other(specify): **Refundable Deposits**	38,613	38,613	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,413,241	\$ 4,566,058	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		389,000	13
14	Buildings, at Historical Cost		7,131,000	14
15	Leasehold Improvements, at Historical Cost	180,351	2,907,097	15
16	Equipment, at Historical Cost	586,686	803,176	16
17	Accumulated Depreciation (book methods)	(667,956)	(2,805,576)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,507)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction-in-Progress**		10,422	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 99,081	\$ 8,435,119	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,512,322	\$ 13,001,177	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 489,630	\$ 489,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,726	45,726	28
29	Short-Term Notes Payable	145,422	3,532,842	29
30	Accrued Salaries Payable	635,534	635,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,305	27,305	31
32	Accrued Real Estate Taxes(Sch.IX-B)	157,000	157,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,500,617	\$ 4,888,037	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,500,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,500,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,500,617	\$ 9,388,037	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,011,705	\$ 3,613,140	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,512,322	\$ 13,001,177	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 823,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 823,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,188,510	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,188,510	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,011,705	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 921,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 921,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,941,916	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ** Shareholder's Loan **	750,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,691,916	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,613,140	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,048,215	1
2	Discounts and Allowances for all Levels	(4,935,306)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,112,909	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,650,105	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,650,105	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	487,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,024	19
20	Radiology and X-Ray	18,530	20
21	Other Medical Services	88,131	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 604,368	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,571	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,571	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,370,953	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,730,665	31
32	Health Care	4,411,612	32
33	General Administration	1,644,148	33
	B. Capital Expense		
34	Ownership	1,497,638	34
	C. Ancillary Expense		
35	Special Cost Centers	1,692,622	35
36	Provider Participation Fee	73,912	36
	D. Other Expenses (specify):		
37	**Addl.State Fee @\$6.07**	131,846	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,182,443	40
41	Income before Income Taxes (line 30 minus line 40)**	2,188,510	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,188,510	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **Set off on Pg 9 & 5**

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,877	2,109	\$ 77,782	\$ 36.88	1
2	Assistant Director of Nursing	1,978	2,157	70,936	32.89	2
3	Registered Nurses	37,299	41,111	1,233,067	29.99	3
4	Licensed Practical Nurses	8,547	9,339	220,791	23.64	4
5	CNAs & Orderlies	144,401	157,090	1,996,833	12.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	1,934	31,589	16.33	9
10	Activity Assistants	1,432	1,605	18,221	11.35	10
11	Social Service Workers	6,590	7,160	103,680	14.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,315	29,840	326,199	10.93	15
16	Dishwashers					16
17	Maintenance Workers	3,750	4,215	66,970	15.89	17
18	Housekeepers	26,553	28,521	266,793	9.35	18
19	Laundry	7,565	8,374	78,684	9.40	19
20	Administrator	2,031	2,166	71,202	32.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,453	12,859	194,865	15.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,789	2,086	38,575	18.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	284,417	310,566	\$ 4,796,187 *	\$ 15.44	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	560	\$ 16,229	1-3	35
36	Medical Director	675	26,400	9-3	36
37	Medical Records Consultant	150	4,512	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	260	8,063	10-3	39
40	Physical Therapy Consultant	1,335	42,728	10a-3	40
41	Occupational Therapy Consultant	1,455	42,180	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,407	39,401	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	160	4,320	12-3	45
46	Other(specify)				46
47	<u>**Outsourced Fine Dining Program**</u>		249,233	1-3	47
48	<u>**Dementia Consultant**</u>	88	2,461	10a-3	48
49	TOTAL (lines 35 - 48)	6,090	\$ 435,527		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,434	\$ 121,602	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,434	\$ 121,602		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Margaret Ryan	Administrator	N/A	\$ 71,202	Workers' Compensation Insurance		\$ 65,918	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		42,174	Advertising: Employee Recruitment	711	
				FICA Taxes		357,437	Health Care Worker Background Check		
				Employee Health Insurance		302,810	(Indicate # of checks performed 155)	2,385	
				Employee Meals		20,177	Patient Background Checks	122 1,950	
				Illinois Municipal Retirement Fund (IMRF)*			**Licenses & Fees**	6,340	
				Miscellaneous Employee Benefits		8,739	**Promotional Advertising**	18,694	
				Uniform Allowance		3,492	**Dues & Subscriptions**	5,378	
				Retirement Plan Contribution		52,796			
TOTAL (agree to Schedule V, line 17, col. 1)							**Lancaster Allocation**	62,907	
(List each licensed administrator separately.)							Less: Public Relations Expense	(4,788)	
							Non-allowable advertising	(75,654)	
							Yellow page advertising	()	
B. Administrative - Other									
Description			Amount						
Management Fees - Lancaster, Ltd.			\$ 243,000	**Lancaster Allocation**		5,992			
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 859,535			
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,913
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Health Data Systems, Inc.	Data Processing		\$ 9,679			\$	Out-of-State Travel	\$	
E-Health Solutions Inc	Data Processing		31,937						
Richard Peelo & Associates	Accounting		2,250						
Frost Ruttenberg & Rothblatt	Accounting		1,950				In-State Travel	916	
Personnel Planners, Inc.	Payroll Tax Consultant		880				**Lancaster Allocation**	129	
Law Office of Carter Korey	Legal		574						
Korey Law, LLC	Legal		8,377	***N/A***			Seminar Expense	3,754	
Richard Nakon & Associates	Legal		750				**Lancaster Allocation**	970	
Law Office of Stephen Sher	Legal		2,042						
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)						\$	TOTAL	\$ 5,769	

*** Attach copy of IMRF notifications**

****See instructions.**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	Mar-2004	\$ 1,000	3	\$ 167	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	Apr-2004	2,000	3	333								
3	Painting & Decorating	Apr-2004	5,515	3	920								
4	Painting & Decorating	Sep-2005	1,532	3	510	256							
5	Painting & Decorating	Jul-2006	6,246	3	2,082	2,082	1,041						
6	Painting & Decorating	May-2007	6,440	3	1,070	2,150	2,150	1,070					
7	Painting & Decorating	Apr-2008	1,375	3		458	459	458					
8	Painting & Decorating	Jul-2009	1,267	3			211	422	422	212			
9	Painting & Decorating	Aug-2010	2,739	3				456	913	913	457		
10	Painting & Decorating	Mar-2011	3,953	3					1,318	1,317	1,318		
11	Painting & Decorating	Oct-2011	3,296	3					549	1,099	1,099	549	
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 35,363		\$ 5,082	\$ 4,946	\$ 3,861	\$ 2,406	\$ 3,202	\$ 3,541	\$ 2,874	\$ 549	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

11 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 57,691

Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 73,912

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

N/A

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 20,177

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.