

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0044859</u> Facility Name: <u>Wauconda Care</u> Address: <u>176 Thomas Court</u> <u>Wauconda</u> <u>60084</u> Number City Zip Code County: <u>Lake</u> Telephone Number: <u>(847) 526-5551</u> Fax # <u>(847) 526-0807</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>5/1/2000</u> Type of Ownership: <table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____	☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.			☐ Trust			☐ Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr></table> <table><tr><td rowspan="6">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td>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</td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	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
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																																		
☐ Charitable Corp.	☐ Individual	☐ State																																		
☐ Trust	☐ Partnership	☐ County																																		
IRS Exemption Code _____	☐ Corporation	☐ Other _____																																		
	☐ "Sub-S" Corp.	_____																																		
	☒ Limited Liability Co.																																			
	☐ Trust																																			
	☐ Other _____																																			
Officer or Administrator of Provider	(Signed) _____																																			
	(Type or Print Name) _____ (Date) _____																																			
	(Title) _____																																			
Paid Preparer	(Signed) _____																																			
	* Subject to the attached Accountants' Consulting Report (Date) _____																																			
	(Print Name and Title) _____																																			
	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>																																			
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																																			
	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 Care

0044859 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>135</u>	Skilled (SNF)	<u>135</u>	<u>49,410</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>135</u>	TOTALS	<u>135</u>	<u>49,410</u>	<u>7</u>

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>429</u>	<u>261</u>	<u>10,108</u>	<u>10,798</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>13,262</u>	<u>5,684</u>	<u>127</u>	<u>19,073</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>13,691</u>	<u>5,945</u>	<u>10,235</u>	<u>29,871</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.46%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 5/1/2000

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 5/1/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 135 and days of care provided 8,840

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Wauconda Care # 0044859 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	450,591	103,158	7,486	561,235		561,235		561,235			1
2	Food Purchase		238,921		238,921		238,921	(1,076)	237,845			2
3	Housekeeping	504,957	79,445		584,402		584,402		584,402			3
4	Laundry	42,035	34,821		76,856		76,856		76,856			4
5	Heat and Other Utilities			199,288	199,288		199,288	(11,730)	187,558			5
6	Maintenance	85,019	26	343,708	428,753		428,753	(44,988)	383,765			6
7	Other (specify):*											7
8	TOTAL General Services	1,082,602	456,371	550,482	2,089,455		2,089,455	(57,794)	2,031,661			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,189,496	530,284	18,922	4,738,702		4,738,702	12,474	4,751,176			10
10a	Therapy		19,632		19,632		19,632		19,632			10a
11	Activities	96,853	16,368	2,456	115,677		115,677		115,677			11
12	Social Services	98,950		5,574	104,524		104,524		104,524			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,385,299	566,284	38,952	4,990,535		4,990,535	12,474	5,003,009			16
	C. General Administration											
17	Administrative	110,010		524,000	634,010		634,010	(110,498)	523,512			17
18	Directors Fees											18
19	Professional Services			72,630	72,630		72,630	20,953	93,583			19
20	Dues, Fees, Subscriptions & Promotions			74,248	74,248		74,248	(36,004)	38,244			20
21	Clerical & General Office Expenses	421,688	17,664	425,988	865,340		865,340	(154,769)	710,571			21
22	Employee Benefits & Payroll Taxes			1,354,925	1,354,925		1,354,925		1,354,925			22
23	Inservice Training & Education											23
24	Travel and Seminar			891	891		891	3,540	4,431			24
25	Other Admin. Staff Transportation			3,139	3,139		3,139		3,139			25
26	Insurance-Prop.Liab.Malpractice			169,626	169,626		169,626	96	169,722			26
27	Other (specify):*							60,000	60,000			27
28	TOTAL General Administration	531,698	17,664	2,625,447	3,174,809		3,174,809	(216,683)	2,958,126			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,999,599	1,040,319	3,214,881	10,254,799		10,254,799	(262,003)	9,992,796			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			48,912	48,912		48,912	378,282	427,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,235	96,235		96,235	116,084	212,319			32
33	Real Estate Taxes			290,404	290,404		290,404	24,676	315,080			33
34	Rent-Facility & Grounds			1,264,296	1,264,296		1,264,296	(1,250,137)	14,159			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,699,847	1,699,847		1,699,847	(731,095)	968,752			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		382,565	972,751	1,355,316		1,355,316		1,355,316			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,810	201,810		201,810		201,810			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		382,565	1,174,561	1,557,126		1,557,126		1,557,126			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,999,599	1,422,884	6,089,289	13,511,772		13,511,772	(993,098)	12,518,674			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	(11,730)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	133,541	30		9
10	Interest and Other Investment Income	(1,294)	32		10
11	Discounts, Allowances, Rebates & Refunds	(308)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(474)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(331,588)	21		24
25	Fund Raising, Advertising and Promotional	(32,416)	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	(327,862)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (572,131)		\$	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)	(420,967)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (420,967)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (993,098)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (4,664)	21	1
2	Vending Commisions	(294)	02	2
3	Non-Allowable Legal	(13,471)	19	3
4	Building Co. - Licenses & Fees	(75)	20	4
5	Building Co. - Accounting Fees	(2,472)	19	5
6	Chamber of Commerce	(499)	20	6
7	Prior Period Dues	(650)	20	7
8	Prior Period Background Check	(520)	20	8
9	PAC Dues	(2,430)	20	9
10	Annual Report	(75)	20	10
11	Capitalized R&M	(45,216)	06	11
12	Non-Allowable Interest	(257,495)	32	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	(327,862)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Care # 0044859 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,076)											(1,076)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,730)											(11,730)	5
6	Maintenance	(45,216)		228									(44,988)	6
7	Other (specify):*													7
8	TOTAL General Services	(58,022)		228									(57,794)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			12,474									12,474	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs			12,474									12,474	16
	C. General Administration													
17	Administrative			(110,498)									(110,498)	17
18	Directors Fees													18
19	Professional Services	(15,943)	2,472	34,424									20,953	19
20	Fees, Subscriptions & Promotions	(36,665)	75	586									(36,004)	20
21	Clerical & General Office Expenses	(336,252)		181,483									(154,769)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			3,540									3,540	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			96									96	26
27	Other (specify):*			60,000									60,000	27
28	TOTAL General Administration	(388,861)	2,547	169,631									(216,683)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(446,883)	2,547	182,333									(262,003)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda Care # 0044859 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	133,541	241,830	2,911									378,282	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(258,789)	353,625	21,248									116,084	32
33	Real Estate Taxes		24,676										24,676	33
34	Rent-Facility & Grounds		(1,253,696)	3,559									(1,250,137)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(125,248)	(633,565)	27,718									(731,095)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(572,131)	(631,018)	210,051									(993,098)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34	Rent	\$ 1,253,696	Wauconda Associates		\$	(1,253,696)	1
2	V	32	Interest	96,235	Wauconda Associates		449,860	353,625	2
3	V	30	Depreciation		Wauconda Associates		241,830	241,830	3
4	V	20	License and Fees		Wauconda Associates		75	75	4
5	V	19	Accounting Fees		Wauconda Associates		2,472	2,472	5
6	V	33	Real Estate Taxes		Wauconda Associates		24,676	24,676	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,349,931			\$ 718,913	\$ * (631,018)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	LAURENCE ZUNG DESCENDANTS TRUST	66.66%	OAKBROOK HEALTHCARE CENTER	OAKBROOK	WAUCONDA ASSOCIATES	WAUCONDA	BUILDING CO	1
2	DISCRETIONARY TRUST FOR JENNIFER	16.67%	FAIRMONT CARE CENTRE	CHICAGO	LANCASTER LTD	CHICAGO	MANAGEMENT CO	2
3	DISCRETIONARY TRUST FOR JULIE T.Y.	16.67%						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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	\$	Lancaster, LTD		\$ 34,424	\$ 34,424	15
16	V	21	Clerical Expenditures		Lancaster, LTD		181,483	181,483	16
17	V	27	Employee Benefits		Lancaster, LTD		23,579	23,579	17
18	V	24	Seminar and Travel		Lancaster, LTD		3,540	3,540	18
19	V	17	Administrative Consulting		Lancaster, LTD		336,835	336,835	19
20	V	10	Medical Supplies		Lancaster, LTD		12,474	12,474	20
21	V	20	Dues, Fees and Subscriptions		Lancaster, LTD		586	586	21
22	V	30	Depreciation		Lancaster, LTD		2,911	2,911	22
23	V	6	Repairs and Maintenance		Lancaster, LTD		228	228	23
24	V	27	Payroll Taxes		Lancaster, LTD		32,385	32,385	24
25	V	32	Interest		Lancaster, LTD		21,248	21,248	25
26	V	26	General Insurance		Lancaster, LTD		96	96	26
27	V	34	Rental Expenditures		Lancaster, LTD		3,559	3,559	27
28	V								28
29	V	17	Officer's Salaries		Lancaster, LTD		76,667	76,667	29
30	V	27	Payroll Taxes - Officer		Lancaster, LTD		4,036	4,036	30
31	V	17	Management Fees	524,000	Lancaster, LTD			(524,000)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 524,000			\$ 734,051	\$ * 210,051	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 12/31/20

Facility Name & ID Number	Wauconda Care
--------------------------------------	----------------------

0044859

Report Period Beginning:

01/01/20

Ending: 12/31/20

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

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Christopher Vicere	Hours Worked	48	3	\$ 230,000	\$ 230,000	16	\$ 76,667	1
2	17	Christopher Vicere-payroll tax	Hours Worked	48	3	12,108		16	4,036	2
3										3
4	19	Professional Services	Census Days	105,909	3	122,053		29,871	34,424	4
5	21	Clerical Expenditures	Census Days	105,909	3	643,456	599,894	29,871	181,483	5
6	27	Employee Benefits	Census Days	105,909	3	83,602		29,871	23,579	6
7	24	Seminar and Travel	Census Days	105,909	3	12,551		29,871	3,540	7
8	17	Administrative Consulting	Census Days	105,909	3	1,194,264	1,179,264	29,871	336,835	8
9	10	Medical Supplies	Census Days	105,909	3	44,226		29,871	12,474	9
10	20	Dues, Fees and Subscriptions	Census Days	105,909	3	2,079		29,871	586	10
11	30	Depreciation	Census Days	105,909	3	10,321		29,871	2,911	11
12	6	Repairs and Maintenance	Census Days	105,909	3	808		29,871	228	12
13	27	Payroll Taxes	Census Days	105,909	3	114,821		29,871	32,385	13
14	32	Interest	Census Days	105,909	3	75,336		29,871	21,248	14
15	26	General Insurance	Census Days	105,909	3	341		29,871	96	15
16	34	Rental Expenditures	Census Days	105,909	3	12,618		29,871	3,559	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,558,584	\$ 2,009,158		\$ 734,051	25

Facility Name & ID Number	Wauconda Care
--------------------------------------	----------------------

0044859

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/20

Ending: 12/31/20

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/20

Fax NumberIL478-2471

Ending: 12/31/20

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

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

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle National Trust, N.A.		X	Mortgage	\$29,401.00	2/2009	\$ 3,595,000	\$ 2,049,291			\$ 192,365	1	
2			X									2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$29,401.00		\$ 3,595,000	\$ 2,049,291			\$ 192,365	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1,294)	10	
11	Allocated from Lancaster LTD		X								21,248	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 19,954	14	
15	TOTALS (line 9+line14)						\$ 3,595,000	\$ 2,049,291			\$ 212,319	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Wauconda Care COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 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 2015.

B. **Real Estate Tax Cost Allocations**

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10B

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

36,038

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	135		2009	1970	\$ 7,131,000	\$ 241,830	39	\$ 182,846	\$ (58,984)	\$ 3,125,787	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	2,862		20			2,862	9
10	Various			2001	117,387		20	(41)	(41)	117,346	10
11	Various			2002	1,100		20			1,100	11
12	Various			2005	2,360,516		20	111,478	111,478	1,734,274	12
13	Various			2007	241,562		20	9,826	9,826	177,701	13
14	Various			2008	38,795		20	1,940	1,940	23,440	14
15	Various			2009	36,413		20	408	408	34,459	15
16	Various			2010	12,500		20	625	625	12,188	16
17	Various			2012	49,773		20	1,170	1,170	44,848	17
18	Various			2013	78,381		20	3,101	3,101	43,507	18
19	Various			2014	329,770		20	7,117	7,117	236,104	19
20	Various			2015	39,929		20	1,997	1,997	12,563	20
21	Various			2016	28,668		20	1,434	1,434	6,780	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Related Building Company (Pages 12F & 12G)		679,270			34,255	34,255	171,960	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			48,912			(48,912)		69
70	TOTAL (lines 4 thru 69)		\$ 11,147,926	\$ 290,742		\$ 356,156	\$ 65,414	\$ 5,744,919	70

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

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,147,926	\$ 290,742		\$ 356,156	\$ 65,414	\$ 5,744,919	1
2	Digital Pbx W/ 48 Phone Lines	2017	24,396		20	1,220	1,220	4,772	2
3	Patch/Paint Ceiling, Walls, Metal Frames, Doors/Countertops - Ki	2017	3,500		20	175	175	613	3
4	Installed Wanderguard System	2017	2,654		20	133	133	509	4
5	Repaired Heat Exchanger	2017	2,800		20	140	140	548	5
6	Installed New Rooftop Hvac	2017	5,500		20	275	275	894	6
7	1St Floor Shower Rooms - Flooring, Paint, Wall Work	2018	7,000		20	350	350	1,050	7
8	40 Gallon Electric Water Heater Repair - Repipe Water Lines	2018	2,747		20	137	137	412	8
9	Replace Kitchen Cooler, Heat Exchanger - Gaskets, Belt	2018	2,718		20	136	136	385	9
10	12.5 Ton Hvac Unit Installation	2018	14,500		20	725	725	1,994	10
11	Network Upgrade - Cable, Jack, Analog Gateway Installation	2018	11,348		20	567	567	2,194	11
12	Conduit & Cable Work - Rms 302-315, Jack Installation	2018	3,992		20	200	200	400	12
13	Asphalt Parking Lot Repair/Paving - Front Entrance & Rear Lot	2019	13,905		20	695	695	1,390	13
14	Hydro Excavate And Repair Ductile Iron Water Service	2019	19,136		20	957	957	1,914	14
15	Shower Rm-Install New Wall/Tiles,Paint Ceiling	2019	4,500		20	225	225	450	15
16	Shower Rm - Drains,Floor,Electrical & Pipe Work	2019	4,967		20	248	248	496	16
17	Replaced 62 Sprinkler Heads	2019	4,327		20	216	216	432	17
18	Rm 121 Shower Room - Tile Installation	2019	5,000		20	250	250	500	18
19	Replace Hvac Unit	2019	6,850		20	343	343	686	19
20	Flooring-Underground Conduit & Wiring Repair	2019	2,579		20	129	129	258	20
21	Bathroom Pipe Repair	2019	2,980		20	149	149	298	21
22	Fire Sprinkler System Repairs	2020	4,556		20	228	228	228	22
23	Installation Of 4 Global Plasma Generators	2020	2,500		20	125	125	125	23
24	Nurse Call System - Install Circuit Breakers	2020	2,500		20	125	125	125	24
25	Installation Of New Rooftop Hvac Unit	2020	5,800		20	290	290	290	25
26	Replacement Of 100 Wing Hvac Unit	2020	7,640		20	382	382	190	26
27	Install New Electric Door Locks	2020	6,560		20	328	328	328	27
28	Install Camera And Wiring	2020	2,600		20	130	130	130	28
29	Piping Work - - Cut Out Old Cast Iron, Piped New Pvc In Rsdnt R	2020	3,685		20	184	184	184	29
30	Hot Water Heater Repair	2020	9,375		20	469	469	469	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,338,541	\$ 290,742		\$ 365,687	\$ 74,945	\$ 5,767,183	34

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

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Hallway Trim Work on Frames and Doors	2015	13,730		20	687	687	4,121	9
10	Convert Dementia Area to new Physical Therapy Gym	2016	236,806		20	11,910	11,910	59,550	10
11	PT Gym - New Wood Floor/Wallpaper/Lighting/Window Treatment	2016	37,241		20	1,862	1,862	9,310	11
12	Convert Physical Therapy Gym to New Dementia Area	2016	125,000		20	6,471	6,471	32,355	12
13	Dementia Area - New Wood Floor/Wallpaper/Window Treatment	2016	16,853		20	843	843	4,214	13
14	New Roof	2016	214,140		20	10,707	10,707	53,535	14
15	Offices/Conferences - Installed new wall tile/walls/electrical/paint	2016	23,500		20	1,175	1,175	5,875	15
16	Installed 2 new sinks/electric for pumps/water lines/faucets	2016	12,000		20	600	600	3,000	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 679,270	\$		\$ 34,255	\$ 34,255	\$ 171,960	34

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

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 679,270	\$		\$ 34,255	\$ 34,255	\$ 171,960	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 679,270	\$		\$ 34,255	\$ 34,255	\$ 171,960	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)
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	\$ 572,724	\$ 2,911	\$ 57,272	\$ 54,361	10	\$ 385,341	71
72	Current Year Purchases	42,358		4,236	4,236	10	4,236	72
73	Fully Depreciated Assets	963,563				10	963,563	73
74								74
75	TOTALS	\$ 1,578,645	\$ 2,911	\$ 61,507	\$ 58,596		\$ 1,353,139	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,785,997	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 293,653	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 427,194	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 133,541	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,120,322	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	CIP	\$ 839,165	92
93			93
94			94
95		\$ 839,165	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Parking Space/Pod Storage				10,600			5
6	Allocated from Lancaster LTD				3,559			6
7	TOTAL				\$14,159			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

Fiscal Year EndingAnnual Rent

12. /2021\$
13. /2022\$
14. /2023\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

	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 - 03	hrs	\$		\$ 373,626	\$		\$ 373,626	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			131,179			131,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			427,125			427,125	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				330,255		330,255	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					40,821	52,310		93,131	13
14	TOTAL			\$		\$ 972,751	\$ 382,565		\$ 1,355,316	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 61,698	\$ 61,698	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,016,868	3,016,868	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,075	49,075	6
7	Other Prepaid Expenses	3,000	3,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	835	835	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,131,476	\$ 3,131,476	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		868,811	13
14	Buildings, at Historical Cost		6,211,911	14
15	Leasehold Improvements, at Historical Cost	354,658	5,090,392	15
16	Equipment, at Historical Cost	791,019	1,124,334	16
17	Accumulated Depreciation (book methods)	(1,089,383)	(7,135,151)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	45,873	885,038	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 102,167	\$ 7,045,335	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,233,643	\$ 10,176,811	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 878,733	\$ 878,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,717	298,717	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	61,855	61,855	31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,000	300,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	721,244	8,353,426	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,260,549	\$ 9,892,730	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,049,291	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,890,050	(485,750)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,890,050	\$ 1,563,541	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,150,599	\$ 11,456,271	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,916,956)	\$ (1,279,460)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,233,643	\$ 10,176,811	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,815,953)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,815,949)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(101,007)	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)	\$ (101,007)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,916,956)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wauconda Care

0044859

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,772,260	1
2	Discounts and Allowances for all Levels	(3,706,828)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,065,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,288,306	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,288,306	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	361,793	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	130,429	19
20	Radiology and X-Ray	22,399	20
21	Other Medical Services	38,176	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 552,797	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,294	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,294	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,502,936	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,502,936	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,410,765	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,089,455	31
32	Health Care	4,990,535	32
33	General Administration	3,174,809	33
	B. Capital Expense		
34	Ownership	1,699,847	34
	C. Ancillary Expense		
35	Special Cost Centers	1,355,316	35
36	Provider Participation Fee	201,810	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,511,772	40
41	Income before Income Taxes (line 30 minus line 40)**	(101,007)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (101,007)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,854,901	44
45	Private Pay - Net Inpatient Revenue	1,674,285	45
46	Medicare - Net Inpatient Revenue	2,988,897	46
47	Other-(specify) Insurance	547,349	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,065,432	49

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

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

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

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

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	2,005	\$ 133,979	\$ 60.60	1
2	Assistant Director of Nursing	547	26,065	43.51	2
3	Registered Nurses	39,930	1,690,890	38.25	3
4	Licensed Practical Nurses	16,023	532,905	30.71	4
5	CNAs & Orderlies	85,657	1,756,449	18.20	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,939	41,583	19.15	9
10	Activity Assistants	2,839	55,270	17.05	10
11	Social Service Workers	3,809	98,950	23.71	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	5,894	123,595	18.61	14
15	Cook Helpers/Assistants	19,929	326,996	14.60	15
16	Dishwashers				16
17	Maintenance Workers	3,825	85,019	19.88	17
18	Housekeepers	30,797	504,957	14.47	18
19	Laundry	2,513	42,035	14.36	19
20	Administrator	1,914	110,010	51.05	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	16,612	421,688	23.28	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	1,842	49,208	22.67	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	236,075	\$ 5,999,599 *	\$ 22.72	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	267	\$ 7,486	01-03 35
36	Medical Director	233	12,000	09-03 36
37	Medical Records Consultant	161	4,000	10-03 37
38	Nurse Consultant			38
39	Pharmacist Consultant	425	11,028	10-03 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	112	2,456	11-03 44
45	Social Service Consultant	254	5,574	12-03 45
46	Other(specify) <u>Dementia Consultant Per Visit</u>		50	10-03 46
47				47
48				48
49	TOTAL (lines 35 - 48)	1,451	\$ 42,594	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	154	3,844	10-03 52
53	TOTAL (lines 50 - 52)	154	\$ 3,844	53

Facility Name & ID Number <u>Wauconda Care</u>	STATE OF ILLINOIS # <u>0044859</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
---	--	---	--------------------------------

Page 22

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI - \$4,860

(3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,001 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 201,810
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? Yes
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees