FOR BHF USE

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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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0044859

Facility Name: Wauconda Healthcare and Rehabilitation

Address: 176 Thomas Court (Number) | Wauconda (City) | 60084 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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-2010 to 31-Dec-2010 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) _____ 31st March 2011 (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 # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	505	1,606	9,784	11,895	8
9	SNF/PED					9
10	ICF	20,674	11,113	189	31,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,179	12,719	9,973	43,871	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.03%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 1st May 2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 8,932

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31st Dec 2010 Fiscal Year: 31st Dec 2010

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,680	34,400	11,677	368,757		368,757		368,757			1
2	Food Purchase		253,659		253,659	(16,985)	236,674	732	237,406			2
3	Housekeeping	276,611	66,387		342,998		342,998		342,998			3
4	Laundry	76,033	43,084		119,117		119,117		119,117			4
5	Heat and Other Utilities			251,147	251,147		251,147		251,147			5
6	Maintenance	65,370	72,346	155,247	292,963		292,963	687	293,650			6
7	Other (specify):*											7
8	TOTAL General Services	740,694	469,876	418,071	1,628,641	(16,985)	1,611,656	1,419	1,613,075			8
	B. Health Care and Programs											
9	Medical Director			26,400	26,400		26,400		26,400			9
10	Nursing and Medical Records	3,609,918	266,627	146,378	4,022,923		4,022,923		4,022,923			10
10a	Therapy		9,496	22,668	32,164		32,164		32,164			10a
11	Activities	45,544	33,124		78,668		78,668		78,668			11
12	Social Services	63,053		1,827	64,880		64,880		64,880			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,718,515	309,247	197,273	4,225,035		4,225,035		4,225,035			16
	C. General Administration											
17	Administrative	71,811		243,000	314,811		314,811	(73,985)	240,826			17
18	Directors Fees											18
19	Professional Services			61,117	61,117		61,117	12,502	73,619			19
20	Dues, Fees, Subscriptions & Promotions			52,889	52,889		52,889	(38,730)	14,159			20
21	Clerical & General Office Expenses	214,303	60,471	312,574	587,348		587,348	(191,542)	395,806			21
22	Employee Benefits & Payroll Taxes			790,182	790,182	16,985	807,167	5,644	812,811			22
23	Inservice Training & Education			5,252	5,252		5,252		5,252			23
24	Travel and Seminar			4,577	4,577		4,577	327	4,904			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			280,963	280,963		280,963		280,963			26
27	Other (specify):*							22,117	22,117			27
28	TOTAL General Administration	286,114	60,471	1,750,554	2,097,139	16,985	2,114,124	(263,667)	1,850,457			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,745,323	839,594	2,365,898	7,950,815		7,950,815	(262,248)	7,688,567			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation #0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			115,761	115,761		115,761	549,205	664,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,569	4,569		4,569	930,342	934,911			32
33	Real Estate Taxes			117,001	117,001		117,001		117,001			33
34	Rent-Facility & Grounds			1,239,615	1,239,615		1,239,615	(1,200,000)	39,615			34
35	Rent-Equipment & Vehicles			1,250	1,250		1,250		1,250			35
36	Other (specify):*											36
37	TOTAL Ownership			1,478,196	1,478,196		1,478,196	279,547	1,757,743			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		399,129	755,702	1,154,831		1,154,831		1,154,831			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):*											43
44	TOTAL Special Cost Centers		399,129	829,614	1,228,743		1,228,743		1,228,743			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,745,323	1,238,723	4,673,708	10,657,754		10,657,754	17,299	10,675,053			45

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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 Reference	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	(148,988)	30		9
10	Interest and Other Investment Income	(374)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	732	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		24		19
20	Contributions	(600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(285,006)	21		24
25	Fund Raising, Advertising and Promotional	(84,793)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,128)	20		28
29	Other-Attach Schedule Page 5A attached	(333)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (520,490)		$	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)	537,789	Pg 6& 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 537,789		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 17,299		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

Wauconda Healthcare and Rehabilitation

ID# 0044859

Report Period Beginning: 1-Jan-2010

Ending: 31-Dec-2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Costs (expended in 2010)	$ (2,739)	6	1
2	Deferred Maintenance Costs (to write off in 2010)	2,406	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**	(333)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	732	0	0	0	0	0	0	0	0	0	0	732	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(333)	1,020	0	0	0	0	0	0	0	0	0	687	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	399	1,020	0	0	0	0	0	0	0	0	0	1,419	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(73,985)	0	0	0	0	0	0	0	0	0	(73,985)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,752	3,750	0	0	0	0	0	0	0	0	12,502	19
20	Fees, Subscriptions & Promotions	(86,521)	47,791	0	0	0	0	0	0	0	0	0	(38,730)	20
21	Clerical & General Office Expenses	(285,006)	93,464	0	0	0	0	0	0	0	0	0	(191,542)	21
22	Employee Benefits & Payroll Taxes	0	5,644	0	0	0	0	0	0	0	0	0	5,644	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	327	0	0	0	0	0	0	0	0	0	327	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	22,117	0	0	0	0	0	0	0	0	0	22,117	27
28	**TOTAL General Administration**	(371,527)	104,110	3,750	0	0	0	0	0	0	0	0	(263,667)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(371,128)	105,130	3,750	0	0	0	0	0	0	0	0	(262,248)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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	(148,988)	3,288	694,905	0	0	0	0	0	0	0	0	549,205	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(374)	955	929,761	0	0	0	0	0	0	0	0	930,342	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,200,000)	0	0	0	0	0	0	0	0	(1,200,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(149,362)	4,243	424,666	0	0	0	0	0	0	0	0	279,547	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(520,490)	109,373	428,416	0	0	0	0	0	0	0	0	17,299	45

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee Income	$ 243,000	Lancaster, Ltd.	100.00%	$	$ (243,000)	1
2	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	54,948	54,948	2
3	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	22,117	22,117	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	8,752	8,752	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	93,464	93,464	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	5,644	5,644	6
7	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	327	327	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	114,067	114,067	8
9	V	20	Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	47,791	47,791	9
10	V	30	Depreciation		Lancaster, Ltd.	100.00%	3,288	3,288	10
11	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	1,020	1,020	11
12	V	32	Interest		Lancaster, Ltd.	100.00%	5,941	5,941	12
13	V	32	**Direct Interest**		Lancaster, Ltd.	100.00%	(4,986)	(4,986)	13
14	Total			$ 243,000			$ 352,373	$ * 109,373	14

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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		Wauconda Associates		417	417	16
17	V	32	Interest		Wauconda Associates		613,750	613,750	17
18	V	32	Mortgage Interest		Wauconda Associates		315,594	315,594	18
19	V	30	Depreciation		Wauconda Associates		694,905	694,905	19
20	V	19	Accounting Fees		Wauconda Associates		3,750	3,750	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			$ 1,200,000			$ 1,628,416	$ * 428,416	39

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Christopher Vicere	VP-Finance	Administrative		see attached	7.75	16.15	Lancaster	$ 27,474	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	7.75	16.15	Lancaster	27,474	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	$ 54,948		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 # 0044859 Report Period Beginning: 1-Jan-2010 Ending: -Dec-2010

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 [X] 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 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	17	Christopher Vicere	Hours Worked	48	4	$ 170,160	$ 170,160	8	$ 27,474	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	9,439		8	1,524	2
3	17	Cheryl Morris	Hours Worked	48	4	170,160	170,160	8	27,474	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	9,420		8	1,521	4
5										5
6										6
7	19	Professional Services	Census Days	311,995	4	62,241		43,871	8,752	7
8	21	Clerical Expenses	Census Days	311,995	4	664,683	623,280	43,871	93,464	8
9	22	Employee Benefits	Census Days	311,995	4	40,140		43,871	5,644	9
10	24	Seminars and Travel	Census Days	311,995	4	2,324		43,871	327	10
11	17	Administrative Consulting	Census Days	311,995	4	811,207	811,207	43,871	114,067	11
12	20	Marketing Fees	Census Days	311,995	4	332,596	327,507	43,871	46,768	12
13	20	Dues, Fees and Subscriptions	Census Days	311,995	4	7,277		43,871	1,023	13
14	30	Depreciation	Census Days	311,995	4	23,380		43,871	3,288	14
15	6	Repairs and Maintenance	Census Days	311,995	4	7,255		43,871	1,020	15
16	27	Payroll Taxes	Census Days	311,995	4	135,636		43,871	19,072	16
17	32	Interest	Census Days	311,995	4	42,252		43,871	5,941	17
18										18
19										19
20	32	**Direct Interest**							(4,986)	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,488,169	$ 2,102,314		$ 352,373	25

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Trust, N.A.		X	Mortgage	$32,345.15	Feb 2009	$ 3,595,000	$ 3,466,773	Jan 2029	9.0000	$ 315,594	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							5,941	7
8												8
9	TOTAL Facility Related				$32,345.15		$ 3,595,000	$ 3,466,773			$ 935,285	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	$ 3,466,773			$ 935,285	15
										Less: Interest Income	(374)	
											934,911	

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

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

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 143,000	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.)		$ 127,001	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,999)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,000	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.		$ 117,001	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	58,647	8
	2006	68,274	9
	2007	135,430	10
	2008	142,567	11
	2009	127,001	12

****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****

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wauconda Healthcare and Rehabilitation COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-35-200-009	Long-Term HealthCare	$ 120,094.87	$ 120,094.87
2.	09-35-200-059	Long-Term HealthCare	$ 6,697.92	$ 6,697.92
3.	09-35-200-057	Long-Term HealthCare	$ 207.84	$ 207.84
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 127,000.63	$ 127,000.63

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

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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 [X] (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? [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized: None
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	155,632	2009	$ 389,000	1
2					2
3	TOTALS	155,632		$ 389,000	3

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	135		2000		$ 7,131,000	$ 583,130	39	$ 380,777	$ (202,353)	$ 692,680	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Redwood Sign 4x6			2000	2,862	169	15	169		2,060	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	610	12
13	Construction of Dimentia Unit			2006	2,288,579	58,679	40	114,429	55,750	524,466	13
14	Fittings & Fixtures to Dimentia Unit			2006	130,960	15,087	5	26,192	11,105	120,047	14
15	Concrete Sidewalk			2006	7,050	489	15	470	(19)	2,154	15
16	Outside Landscaping			2006	19,800	1,372	15	1,320	(52)	6,050	16
17	New Brick Patio			2006	7,400	494	15	494		2,037	17
18	Dining Area Expansion, Nurses Station & Fitness Club			2007	196,512	5,039	39	9,826	4,787	34,391	18
19	Cabinetry & Lighting for above			2007	45,050	5,190	5	9,010	3,820	31,535	19
20	Renovation of Roof			2007	24,000		39	2,400	2,400	8,000	20
21	Preconstruction planning, Architectural & Auto CAD Work			2008	4,295	110	15	214	104	446	21
22	Demolition, Removal of Debris & Temporary Costructior			2008	3,500	89	15	175	86	367	22
23	Reconstruction of Dry Wall, Windows & Doors per Plan			2008	26,000	667	15	1,300	633	2,707	23
24	Installation of Suspended Ceiling & Electrical fitting/pipes			2008	5,000	128	15	250	122	520	24
25	Resurfacing of Parking Lot			2009	8,165	388	15	544	156	907	25
26	Fire Rated Door Frame & Fixtures			2009	1,870	48	10	187	139	265	26
27	Hot water heating Boiler			2009	11,500	295	10	1,150	855	1,533	27
28	Mirrored Walls, Windows & Tiles in Therapy Room			2009	16,748	429	10	1,675	1,246	2,931	28
29	4 Units of 120 Volts Electrical Panels in Nursing Stations			2010	12,500	67	10	313	246	313	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	$ 671,870		$ 550,968	$ (120,902)	$ 1,552,224	70

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 413,908	$ 49,387	$ 81,524	$ 32,137	7	$ 293,806	71
72	Current Year Purchases	141,284	87,011	24,407	(62,604)	7	24,407	72
73	Fully Depreciated Assets	211,306	2,398	4,779	2,381	7	211,306	73
74	**Lancaster Allocation**		3,288	3,288			14,615	74
75	TOTALS	$ 766,498	$ 142,084	$ 113,998	$ (28,086)		$ 544,134	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,217,594	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 813,954	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 664,966	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (148,988)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,096,358	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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. [X] 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	**Off-site Clerical Office**				39,615			5
6								6
7	TOTAL				$ 39,615 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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 [X] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,250 Description: Oxygen Concentrators @ $50 each.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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	$		$ 306,342	$		$ 306,342	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			67,901			67,901	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			381,459			381,459	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-2	hrs				7,179		7,179	8
9	Pharmacy	39-2	# of prescrpts				336,845		336,845	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					33,203		33,203	12
13	Other (specify): **Speciality Beds**	39-2					21,902		21,902	13
14	TOTAL			$		$ 755,702	$ 399,129		$ 1,154,831	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.

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2010 **(last day of reporting year)**

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	$ 900	$ 900	1
2	Cash-Patient Deposits	44,621	44,621	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,513,568	2,513,568	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,775	34,775	6
7	Other Prepaid Expenses	2,000	2,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,595,864	$ 2,595,864	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	550,007	766,497	16
17	Accumulated Depreciation (book methods)	(589,011)	(2,203,399)	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)**	$ 141,347	$ 9,000,617	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,737,211	$ 11,596,481	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 279,217	$ 279,217	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,776	44,776	28
29	Short-Term Notes Payable	844,233	4,355,474	29
30	Accrued Salaries Payable	590,636	590,636	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,154	22,154	31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,000	133,000	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)**	$ 1,914,016	$ 5,425,257	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)**	$ 1,914,016	$ 9,925,257	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 823,195	$ 1,671,224	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,737,211	$ 11,596,481	48

***(See instructions.)**

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 553,419	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 553,419	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,776	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)**	$ 269,776	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)**	$ 823,195	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,207,621	1
2	Restatements (describe):		2
3			3
4	Adjustments in Depriciation for Tax Purposes	(127,757)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,079,864	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(158,640)	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)**	$ 591,360	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)**	$ 1,671,224	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,660,773	1
2	Discounts and Allowances for all Levels	(3,123,069)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,537,704	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,798,990	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,798,990	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,535	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	472,160	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,856	19
20	Radiology and X-Ray	18,840	20
21	Other Medical Services	83,071	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 590,462	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	374	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 374	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)**	$ 10,927,530	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,628,641	31
32	Health Care	4,225,035	32
33	General Administration	2,097,139	33
	B. Capital Expense		
34	Ownership	1,478,196	34
	C. Ancillary Expense		
35	Special Cost Centers	1,154,831	35
36	Provider Participation Fee	73,912	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,657,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	269,776	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 269,776	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 Taxpaye

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

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,165	2,431	$ 87,987	$ 36.19	1
2	Assistant Director of Nursing	1,967	2,099	73,178	34.86	2
3	Registered Nurses	40,700	44,268	1,313,278	29.67	3
4	Licensed Practical Nurses	6,992	7,695	182,964	23.78	4
5	CNAs & Orderlies	139,638	150,795	1,913,931	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,991	2,246	36,767	16.37	9
10	Activity Assistants	674	764	8,777	11.49	10
11	Social Service Workers	4,028	4,521	63,053	13.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,036	28,950	322,680	11.15	15
16	Dishwashers					16
17	Maintenance Workers	3,655	4,077	65,370	16.03	17
18	Housekeepers	27,397	29,453	276,611	9.39	18
19	Laundry	7,772	8,254	76,033	9.21	19
20	Administrator	1,801	2,065	71,811	34.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,073	14,636	214,303	14.64	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	1,821	2,086	38,580	18.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	279,710	304,340	$ 4,745,323 *	$ 15.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	402	$ 11,677	1-3	35
36	Medical Director	675	26,400	9-3	36
37	Medical Records Consultant	140	4,416	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	544	17,413	10-3	39
40	Physical Therapy Consultant	325	11,883	10a-3	40
41	Occupational Therapy Consultant	183	5,451	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	190	5,334	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	66	1,827	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,525	$ 84,401		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,256	$ 124,549	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,256	$ 124,549		53

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathryn Berg	Administrator	N/A	$ 71,811
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,811

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 243,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Tax Consult	$ 1,130
Richard Peelo	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,950
SourceCorp Professional Svcs	Accounting	10,500
Law Office of Carter Korey	Legal	9,167
Richard Nakon & Associates	Legal	1,652
Law Office of Stephan Sher	Legal	932
E Health Solutions, Inc.	Data Processing	25,287
LTCAC, Inc.	Data Processing	1,089
Accu-Med Services Inc.	Data Processing	1,104
Health Data Systems	Data Processing	6,056
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 61,117

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,569
Unemployment Compensation Insurance	37,176
FICA Taxes	348,950
Employee Health Insurance	276,691
Employee Meals	16,985
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	6,935
Employee Uniforms	377
Retirement Plan Contributions	53,984
Employment Fees	6,500
Lancaster Allocation	5,644
TOTAL (agree to Schedule V, line 22, col.8)	$ 812,811

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
** N/A **		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,742
Health Care Worker Background Check	5,700
(Indicate # of checks performed 198)	
Patient Background Checks 182	
Advertising & Promotions	37,630
Licenses and Fees	3,366
Dues and Subscriptions	3,456
Lancaster Allocation	47,791
Less: Public Relations Expense	(37,602)
Non-allowable advertising	(47,791)
Yellow page advertising	(1,128)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,159

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,871
Seminar Expense	1,706
Lancaster Allocation	327
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,904

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 28,114		$ 5,082	$ 4,946	$ 3,861	$ 2,406	$ 1,335	$ 1,125	$ 457	$	$

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-201(

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,935** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **73,912**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,985** 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 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.