FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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-2012 to 31-Dec-2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ 29th March, 2013 (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-2012 Ending: 31-Dec-2012

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	49,410	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	49,410	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		583	11,506	12,089	8
9	SNF/PED					9
10	ICF	17,739	11,916	93	29,748	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,739	12,499	11,599	41,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.67%

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 10,463

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 2012 Fiscal Year: 31st Dec 2012

* 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-2012 Ending: 31-Dec-2012

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	360,699	37,253	120,726	518,678		518,678		518,678			1
2	Food Purchase		309,952		309,952	(23,293)	286,659	(986)	285,673			2
3	Housekeeping	296,701	69,620		366,321		366,321		366,321			3
4	Laundry	79,424	33,992		113,416		113,416		113,416			4
5	Heat and Other Utilities			172,627	172,627		172,627		172,627			5
6	Maintenance	58,863	188,555	149,706	397,124		397,124	(2,535)	394,589			6
7	Other (specify):*											7
8	TOTAL General Services	795,687	639,372	443,059	1,878,118	(23,293)	1,854,825	(3,521)	1,851,304			8
	B. Health Care and Programs											
9	Medical Director			28,650	28,650		28,650		28,650			9
10	Nursing and Medical Records	3,786,407	287,229	64,151	4,137,787		4,137,787		4,137,787			10
10a	Therapy		10,038	161,388	171,426		171,426		171,426			10a
11	Activities	46,722	39,603		86,325		86,325		86,325			11
12	Social Services	98,952		5,760	104,712		104,712		104,712			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,932,081	336,870	259,949	4,528,900		4,528,900		4,528,900			16
	C. General Administration											
17	Administrative	75,761		340,200	415,961		415,961	(125,013)	290,948			17
18	Directors Fees											18
19	Professional Services			58,931	58,931		58,931	29,534	88,465			19
20	Dues, Fees, Subscriptions & Promotions			60,954	60,954		60,954	(36,870)	24,084			20
21	Clerical & General Office Expenses	230,704	66,255	103,180	400,139		400,139	35,143	435,282			21
22	Employee Benefits & Payroll Taxes			855,569	855,569	23,293	878,862	12,369	891,231			22
23	Inservice Training & Education			1,260	1,260		1,260	8,399	9,659			23
24	Travel and Seminar			8,739	8,739		8,739	2,033	10,772			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,170	72,170		72,170		72,170			26
27	Other (specify):* *Payroll Taxes (Sch VII)							26,704	26,704			27
28	TOTAL General Administration	306,465	66,255	1,501,003	1,873,723	23,293	1,897,016	(47,701)	1,849,315			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,034,233	1,042,497	2,204,011	8,280,741		8,280,741	(51,222)	8,229,519			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-2012 Ending: 31-Dec-2012

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			62,518	62,518		62,518	536,127	598,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							895,862	895,862			32
33	Real Estate Taxes			209,810	209,810		209,810		209,810			33
34	Rent-Facility & Grounds			1,253,567	1,253,567		1,253,567	(1,200,000)	53,567			34
35	Rent-Equipment & Vehicles			7,890	7,890		7,890		7,890			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,533,785	1,533,785		1,533,785	231,989	1,765,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		485,148	1,049,976	1,535,124		1,535,124		1,535,124			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,115	74,115		74,115		74,115			42
43	Other (specify):* ***Addl.State Fee @$6.07****			206,755	206,755		206,755		206,755			43
44	**TOTAL Special Cost Centers**		485,148	1,330,846	1,815,994		1,815,994		1,815,994			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,034,233	1,527,645	5,068,642	11,630,520		11,630,520	180,767	11,811,287			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-2012 Ending: 31-Dec-2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	127,134	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(986)	2		13
14	Non-Care Related Interest	(9,925)	32		14
15	Non-Care Related Owner's Transactions		30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions		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	(59,154)	21		24
25	Fund Raising, Advertising and Promotional	(104,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(2,777)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,699)		$	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)	231,466	6, 6A&6B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 231,466		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 180,767		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

STATE OF ILLINOIS **Page 5A**

Wauconda Healthcare and Rehabilitation

ID# **0044859**

Report Period Beginning: **1-Jan-2012**

Ending: **31-Dec-2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2012)	$ (9,477)	6	1
2	Deferred Maintenance Cost (allocated for 2012)	6,700	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**	(2,777)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 **Report Period Beginning:** 1-Jan-2012 **Ending:** 31-Dec-2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(986)	0	0	0	0	0	0	0	0	0	0	(986)	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	(2,777)	242	0	0	0	0	0	0	0	0	0	(2,535)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,763)	242	0	0	0	0	0	0	0	0	0	(3,521)	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	131,851	(256,864)	0	0	0	0	0	0	0	0	(125,013)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,949	0	24,585	0	0	0	0	0	0	0	29,534	19
20	Fees, Subscriptions & Promotions	(104,991)	68,121	0	0	0	0	0	0	0	0	0	(36,870)	20
21	Clerical & General Office Expenses	(59,154)	94,297	0	0	0	0	0	0	0	0	0	35,143	21
22	Employee Benefits & Payroll Taxes	0	12,369	0	0	0	0	0	0	0	0	0	12,369	22
23	Inservice Training & Education	0	8,399	0	0	0	0	0	0	0	0	0	8,399	23
24	Travel and Seminar	0	2,033	0	0	0	0	0	0	0	0	0	2,033	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	0	26,704	0	0	0	0	0	0	0	0	26,704	27
28	**TOTAL General Administration**	(164,145)	322,019	(230,160)	24,585	0	0	0	0	0	0	0	(47,701)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,908)	322,261	(230,160)	24,585	0	0	0	0	0	0	0	(51,222)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

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	127,134	3,409	0	405,584	0	0	0	0	0	0	0	536,127	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,925)	3,456	7,327	895,004	0	0	0	0	0	0	0	895,862	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(1,200,000)	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	117,209	6,865	7,327	100,588	0	0	0	0	0	0	0	231,989	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)	(50,699)	329,126	(222,833)	125,173	0	0	0	0	0	0	0	180,767	45

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	19	Professional Services	$	Lancaster, Ltd.	100.00%	$ 4,949	$ 4,949	1
2	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	94,297	94,297	2
3	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	12,369	12,369	3
4	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	2,033	2,033	4
5	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	131,851	131,851	5
6	V	20	Marketing Fees		Lancaster, Ltd.	100.00%	67,036	67,036	6
7	V	20	Dues, Fees & Subscriptions		Lancaster, Ltd.	100.00%	1,085	1,085	7
8	V	30	Depreciation		Lancaster, Ltd.	100.00%	3,409	3,409	8
9	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	242	242	9
10	V	32	Interest Paid		Lancaster, Ltd.	100.00%	3,456	3,456	10
11	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	8,399	8,399	11
12	V								12
13	V								13
14	Total			$			$ 329,126	$ * 329,126	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-2012 Ending: 31-Dec-2012

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	17	Management Fee Income	$ 340,200	Lancaster, Ltd.	100.00%	$	$ (340,200)	15
16	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	83,336	83,336	16
17	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	4,215	4,215	17
18	V	27	Payroll Taxes-Staff		Lancaster, Ltd.	100.00%	22,489	22,489	18
19	V								19
20	V								20
21	V	32	**Direct Interest**		Lancaster, Ltd.		7,327	7,327	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			$ 340,200			$ 117,367	$ * (222,833)	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-2012 Ending: 31-Dec-2012

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	32	Wauconda Associates			(32)	16
17	V	32	Interest		Wauconda Associates		613,750	613,750	17
18	V	32	Mortgage Interest		Wauconda Associates		281,286	281,286	18
19	V	30	Depreciation		Wauconda Associates		405,584	405,584	19
20	V	19	Accounting Fees		Wauconda Associates		1,225	1,225	20
21	V	19	Legal Fee		Wauconda Associates		23,360	23,360	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			$ 1,200,032			$ 1,325,205	$ * 125,173	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-2012 Ending: 31-Dec-2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Christopher Vicere	VP-Finance	Administrative		see attached	10	20.83	Lancaster	$ 41,668	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	10	20.83	Lancaster	41,668	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	$ 83,336		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-2012 Ending: -Dec-2012

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	$ 200,004	$ 200,004	10	$ 41,668	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	10,128		10	2,110	2
3	17	Cheryl Morris	Hours Worked	48	4	200,004	200,004	10	41,668	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	10,106		10	2,105	4
5										5
6										6
7	19	Professional Services	Census Days	246,796	4	29,193		41,837	4,949	7
8	21	Clerical Expenses	Census Days	246,796	4	556,256	520,039	41,837	94,297	8
9	22	Employee Benefits	Census Days	246,796	4	72,962		41,837	12,369	9
10	24	Seminars and Travel	Census Days	246,796	4	11,995		41,837	2,033	10
11	17	Administrative Consulting	Census Days	246,796	4	777,789	777,789	41,837	131,851	11
12	20	Marketing Fees	Census Days	246,796	4	395,447	378,904	41,837	67,036	12
13	20	Dues, Fees and Subscriptions	Census Days	246,796	4	6,400		41,837	1,085	13
14	30	Depreciation	Census Days	246,796	4	20,107		41,837	3,409	14
15	6	Repairs and Maintenance	Census Days	246,796	4	1,429		41,837	242	15
16	27	Payroll Taxes	Census Days	246,796	4	132,664		41,837	22,489	16
17	32	Interest	Census Days	246,796	4	20,389		41,837	3,456	17
18	23	Education and Inservice	Census Days	246,796	4	49,545		41,837	8,399	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,494,418	$ 2,076,740		$ 439,166	25

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

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	$29,401.20	Feb 2009	$ 3,595,000	$ 3,007,060	Jan 2029	9.0000	$ 281,286	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harston Investments		X	Working Capital							613,750	6
7	JP Morgan Chase Bank, Plc		X	Working Capital							3,456	7
8												8
9	TOTAL Facility Related				$29,401.20		$ 3,595,000	$ 3,007,060			$ 898,492	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	$ 3,007,060			$ 898,492	15
									Less: Interest Income		(2,630)	
											895,862	

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

Page 4 Line 32 col. 8

*** 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-2012 Ending: 31-Dec-2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 157,000	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.)		$ 178,810	2
3. Under or (over) accrual (line 2 minus line 1).		$ 21,810	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 188,000	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.		$ 209,810	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	135,430	8
	2008	142,567	9
	2009	127,001	10
	2010	152,728	11
	2011	178,810	12

** Accrual is based on 2011 Taxes, adjusted for inflation**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-35-200-009	Long-Term Healthcare	$ 169,793.54	$ 169,793.54
2.	09-35-200-059	Long-Term Healthcare	$ 8,744.72	$ 8,744.72
3.	09-35-200-057	Long-Term Healthcare	$ 272.03	$ 272.03
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 178,810.29	$ 178,810.29

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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-2012 Ending: 31-Dec-2012

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).

None

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 333,230	39	$ 380,777	$ 47,547	$ 1,454,234	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Redwood Sign 4x6			2000	2,862	169	15	169		2,398	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	756	12
13	Construction of Dimentia Unit			2006	2,288,579	58,679	40	114,429	55,750	753,324	13
14	Fittings & Fixtures to Dimentia Unit			2006	130,960		5			130,960	14
15	Concrete Sidewalk			2006	7,050	416	15	469	53	3,093	15
16	Outside Landscaping			2006	19,800	1,168	15	1,320	152	8,690	16
17	New Brick Patio			2006	7,400	494	15	494		3,025	17
18	Dining Area Expansion, Nurses Station & Fitness Club			2007	196,512	5,039	39	9,826	4,787	54,043	18
19	Cabinetry & Lighting for above			2007	45,050	2,595	5	4,505	1,910	45,050	19
20	Renovation of Roof			2007	24,000		39	2,400	2,400	12,800	20
21	Preconstruction planning, Architectural & Auto CAD Work			2008	4,295	110	15	215	105	876	21
22	Demolition, Removal of Debris & Temporary Costructior			2008	3,500	90	15	175	85	717	22
23	Reconstruction of Dry Wall, Windows & Doors per Plan			2008	26,000	667	15	1,300	633	5,307	23
24	Installation of Suspended Ceiling & Electrical fitting/pipes			2008	5,000	128	15	250	122	1,020	24
25	Resurfacing of Parking Lot			2009	8,165	314	15	544	230	1,995	25
26	Fire Rated Door Frame & Fixtures			2009	1,870	49	10	187	138	639	26
27	Hot water heating Boiler			2009	11,500	295	10	1,150	855	3,833	27
28	Mirrored Walls, Windows & Tiles in Therapy Room			2009	16,748	429	10	1,675	1,246	6,281	28
29	4 Units of 120 Volts Electrical Panels in Nursing Stations			2010	12,500	321	10	1,250	929	2,813	29
30	Surveillance Camera Monitoring System in & around Facility			2012	9,990	5,994	5	1,189	(4,805)	1,189	30
31	Air conditioning Duct System in Hallways - 100,200,300 Wings			2012	14,600	203	39	852	649	852	31
32	Installation of DTV, Modulators,Dish Antenna & Cables			2012	10,103	6,062	5	674	(5,388)	674	32
33	Ceiling Mounted Hoyer Patient Lift System			2012	6,280	3,768	5	419	(3,349)	419	33
34	Roof Top HVAC with Heat Exchanger			2012	8,800	9	39	73	64	73	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-2012 Ending: 31-Dec-2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,111,869	$ 420,229		$ 524,415	$ 104,186	$ 2,613,266	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-2012 Ending: 31-Dec-2012

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	$ 291,082	$ 18,122	$ 55,323	$ 37,201	7	$ 178,426	71
72	Current Year Purchases	34,967	20,980	4,262	(16,718)	7	4,262	72
73	Fully Depreciated Assets	512,094	8,771	11,236	2,465	7	512,094	73
74	**Lancaster Allocation**		3,409	3,409			24,169	74
75	TOTALS	$ 838,143	$ 51,282	$ 74,230	$ 22,948		$ 718,951	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)	$ 11,818,823	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 471,511	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 598,645	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 127,134	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,332,217	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-2012 Ending: 31-Dec-2012

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:	**Leased from a Related Entity**			$			3
4	Additions							4
5	**Off-site Clerical Office**				44,567			5
6	***Off-site Vehicle Parking Space***				9,000			6
7	TOTAL				$ 53,567 **			7

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

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 7,890 Description: Rehab.Equip. @$1,300 p.m for 3 mnths & @$1,795 for 2 mnths. Oxygen Concentrators @$50pm. (2X4 Mntl
    (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	None				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-2012 Ending: 31-Dec-2012

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-2012 Ending: 31-Dec-2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 394,788	$		$ 394,788	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			104,487			104,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			550,701			550,701	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-3	hrs				7,942		7,942	8
9	Pharmacy	39-2	# of prescrpts				422,519		422,519	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					37,889		37,889	12
13	Other (specify): **Speciality Beds**	39-2					16,798		16,798	13
14	TOTAL			$		$ 1,049,976	$ 485,148		$ 1,535,124	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-2012 Ending: 31-Dec-2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2012 (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	$ 1,400	$ 11,589	1
2	Cash-Patient Deposits	40,382	40,382	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,192,908	3,192,908	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,231	17,231	6
7	Other Prepaid Expenses	3,250	3,250	7
8	Accounts Receivable (owners or related parties)	1,349,399	1,162,650	8
9	Other(specify): **Refundable Deposits**			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,604,570	$ 4,428,010	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		7,131,000	14
15	Leasehold Improvements, at Historical Cost	230,124	2,956,870	15
16	Equipment, at Historical Cost	621,654	838,144	16
17	Accumulated Depreciation (book methods)	(730,474)	(3,273,678)	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**		160,038	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 121,304	$ 8,681,185	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,725,874	$ 13,109,195	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 495,620	$ 495,620	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,382	40,382	28
29	Short-Term Notes Payable	184,725	3,591,784	29
30	Accrued Salaries Payable	526,566	526,566	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,476	8,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,000	188,000	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)**	$ 1,443,769	$ 4,850,828	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)**	$ 1,443,769	$ 9,350,828	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,282,105	$ 3,758,367	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,725,874	$ 13,109,195	48

*(See instructions.)

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2012 **Ending:** 31-Dec-2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,011,705	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,011,705	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	270,400	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)**	$ 270,400	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,282,105	24	*

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,863,140	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,863,140	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,227	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)**	$ 895,227	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,758,367	24 *

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

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,063,671	1
2	Discounts and Allowances for all Levels	(5,388,333)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,675,338	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,677,699	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,677,699	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	428,968	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,313	19
20	Radiology and X-Ray	17,464	20
21	Other Medical Services	81,213	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 537,958	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,925	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,925	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)**	$ 11,900,920	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,878,118	31
32	Health Care	4,528,900	32
33	General Administration	1,873,723	33
	B. Capital Expense		
34	Ownership	1,533,785	34
	C. Ancillary Expense		
35	Special Cost Centers	1,535,124	35
36	Provider Participation Fee	74,115	36
	D. Other Expenses (specify):		
37			37
38	**Additional State Fee @$6.07**	206,755	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,630,520	40
41	**Income before Income Taxes (line 30 minus line 40)****	270,400	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 270,400	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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. **Set off on Pg 9 & 5****

****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-2012 Ending: 31-Dec-2012

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	1,906	2,131	$ 79,199	$ 37.17	1
2	Assistant Director of Nursing	1,990	2,181	74,465	34.14	2
3	Registered Nurses	36,912	40,112	1,218,663	30.38	3
4	Licensed Practical Nurses	14,531	15,357	363,001	23.64	4
5	CNAs & Orderlies	140,974	155,037	2,013,647	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,922	2,091	34,906	16.69	9
10	Activity Assistants	910	1,032	11,816	11.45	10
11	Social Service Workers	5,603	6,527	98,952	15.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,672	32,072	360,699	11.25	15
16	Dishwashers					16
17	Maintenance Workers	3,205	3,595	58,863	16.37	17
18	Housekeepers	27,771	30,433	296,701	9.75	18
19	Laundry	7,386	8,106	79,424	9.80	19
20	Administrator	1,996	2,211	75,761	34.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,547	14,893	230,704	15.49	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	1,706	1,964	37,432	19.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	290,031	317,742	$ 5,034,233 *	$ 15.84	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	1,634	$ 45,753	1-3	35
36	Medical Director	716	28,650	9-3	36
37	Medical Records Consultant	174	4,512	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	295	7,975	10-3	39
40	Physical Therapy Consultant	3,190	89,301	10a-3	40
41	Occupational Therapy Consultant	1,852	51,863	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	588	17,639	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	220	5,760	12-3	45
46	Other(specify)				46
47	**Outsourced Fine Dining Program**		74,973	1-3	47
48	**Dimentia Consultant**	93	2,585	10a-3	48
49	TOTAL (lines 35 - 48)	8,762	$ 329,011		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,830	$ 51,664	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,830	$ 51,664		53

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Ryan	Administrator	N/A	$ 75,761
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,761

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 340,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 340,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 5,064
E-Health Solutions Inc	Data Processing	31,937
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,950
Personnel Planners, Inc.	Payroll Tax Consultant	1,155
Korey Law, LLC	Legal	11,599
Korey, Cotter, Heather & Richardson	Legal	4,976
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,931

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,255
Unemployment Compensation Insurance	36,835
FICA Taxes	372,915
Employee Health Insurance	302,374
Employee Meals	23,293
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	11,816
Uniform Allowance	351
Retirement Plan Contribution	53,921
Dental Insurance	102
Employment Fees	5,000
Lancaster Allocation	12,369
TOTAL (agree to Schedule V, line 22, col.8)	$ 891,231

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	$ 1,990
Advertising: Employee Recruitment	847
Health Care Worker Background Check (Indicate # of checks performed 187)	5,630
Patient Background Checks 174	2,610
Licenses & Fees	926
Promotional Advertising	42,738
Dues & Subscriptions	6,213
Lancaster Allocation	68,121
Less: Public Relations Expense	(36,870)
Non-allowable advertising	(68,121)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,084

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,462
Lancaster Allocation	1,321
Seminar Expense	6,277
Lancaster Allocation	712
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,772

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wauconda Healthcare and Rehabilitation # 0044859 Report Period Beginning: 1-Jan-2012 Ending: 31-Dec-2012

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	Mar-2004	$ 1,000	3	$ 167	$	$	$	$	$	$	$	$
2	Painting & Decorating	Apr-2004	2,000	3	333								
3	Painting & Decorating	Apr-2004	5,515	3	920								
4	Painting & Decorating	Sep-2005	1,532	3	510	256							
5	Painting & Decorating	Jul-2006	6,246	3	2,082	2,082	1,041						
6	Painting & Decorating	May-2007	6,440	3	1,070	2,150	2,150	1,070					
7	Painting & Decorating	Apr-2008	1,375	3		458	459	458					
8	Painting & Decorating	Jul-2009	1,267	3			211	422	422	212			
9	Painting & Decorating	Aug-2010	2,739	3				456	913	913	457		
10	Painting & Decorating	Mar-2011	3,953	3					1,318	1,317	1,318		
11	Painting & Decorating	Oct-2011	3,296	3					549	1,099	1,099	549	
12	Painting & Decorating	Mar-2012	9,477	3						3,159	3,159	3,159	
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 44,840		$ 5,082	$ 4,946	$ 3,861	$ 2,406	$ 3,202	$ 6,700	$ 6,033	$ 3,708	$

Facility Name & ID Number Wauconda Healthcare and Rehabilitation **#** 0044859 **Report Period Beginning:** 1-Jan-2012 **Ending:** 31-Dec-2012

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,032** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **74,115**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **23,293** 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.