



Facility Name & ID Number Wynscape

# 0041426 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,966	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,494	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	12,878	10,251	6,269	29,398	8
9	SNF/PED					9
10	ICF	24,091	13,220	6	37,317	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,969	23,471	6,275	66,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.22%

D. How many bed-hold days during this year were paid by Public Aid? 0 (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  Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/01/96 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 6,144

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/00 Fiscal Year: 6/30/00  
\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Wynscape

# 0041426

Report Period Beginning:

7/1/99

Ending:

6/30/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>1</b>	<b>A. General Services</b>										
1	Dietary	420,530	5,856	5,801	432,187		432,187		432,187		1
2	Food Purchase		307,068		307,068		307,068	(1,192)	305,876		2
3	Housekeeping	298,407	52,335	2,625	353,367		353,367		353,367		3
4	Laundry	97,665	21,846		119,511		119,511		119,511		4
5	Heat and Other Utilities			148,731	148,731		148,731		148,731		5
6	Maintenance	32,451		98,049	130,500		130,500		130,500		6
7	Other (specify):*										7
<b>8</b>	<b>TOTAL General Services</b>	<b>849,053</b>	<b>387,105</b>	<b>255,206</b>	<b>1,491,364</b>		<b>1,491,364</b>	<b>(1,192)</b>	<b>1,490,172</b>		<b>8</b>
<b>9</b>	<b>B. Health Care and Programs</b>										
9	Medical Director			31,025	31,025		31,025		31,025		9
10	Nursing and Medical Records	3,125,662	275,628	1,015	3,402,305		3,402,305		3,402,305		10
10a	Therapy	72,454	5,090	104,156	181,700		181,700		181,700		10a
11	Activities	174,215			174,215		174,215		174,215		11
12	Social Services	51,814		3,335	55,149		55,149		55,149		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>3,424,145</b>	<b>280,718</b>	<b>139,531</b>	<b>3,844,394</b>		<b>3,844,394</b>		<b>3,844,394</b>		<b>16</b>
<b>17</b>	<b>C. General Administration</b>										
17	Administrative	81,004		456,670	537,674		537,674	184,714	722,388		17
18	Directors Fees										18
19	Professional Services			44,494	44,494		44,494	(4,163)	40,331		19
20	Dues, Fees, Subscriptions & Promotions			31,660	31,660		31,660		31,660		20
21	Clerical & General Office Expenses	308,904	71,576	19,050	399,530		399,530	(20)	399,510		21
22	Employee Benefits & Payroll Taxes			936,005	936,005		936,005		936,005		22
23	Inservice Training & Education			21,740	21,740		21,740		21,740		23
24	Travel and Seminar			2,374	2,374		2,374		2,374		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			5,802	5,802		5,802		5,802		26
27	Other (specify):*										27
<b>28</b>	<b>TOTAL General Administration</b>	<b>389,908</b>	<b>71,576</b>	<b>1,517,795</b>	<b>1,979,279</b>		<b>1,979,279</b>	<b>180,531</b>	<b>2,159,810</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,663,106</b>	<b>739,399</b>	<b>1,912,532</b>	<b>7,315,037</b>		<b>7,315,037</b>	<b>179,339</b>	<b>7,494,376</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number Wynscape

#0041426

Report Period Beginning:

7/1/99

Ending:

6/30/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership			412,518	412,518							30
	Depreciation			412,518	412,518			(23,586)	388,932			
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,760	110,760			(46,417)	64,343			32
33	Real Estate Taxes			105,000	105,000				105,000			33
34	Rent-Facility & Grounds			343,013	343,013				343,013			34
35	Rent-Equipment & Vehicles			23,799	23,799				23,799			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			995,090	995,090			(70,003)	925,087			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,373	72,233	269,606		269,606		269,606			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,742	114,742		114,742		114,742			42
43	Other (specify):* <b>Nonallowable costs</b>			77,509	77,509		77,509	(77,509)				43
44	<b>TOTAL Special Cost Centers</b>		197,373	264,484	461,857		461,857	(77,509)	384,348			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,663,106	936,772	3,172,106	8,771,984		8,771,984	31,827	8,803,811			45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wynscape

# 0041426

Report Period Beginning: 7/1/99

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(74,108)	30		9
10	Interest and Other Investment Income	(46,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,999)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,997)	43		24
25	Fund Raising, Advertising and Promotional	(41,483)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(7,405)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (203,409)		\$	30

OHF 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	2	
		Amount	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)	235,236		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 235,236		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 31,827		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wmscape

ID# 0041426

Report Period Beginning: 7/1/99

Ending: 6/30/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	<b>Total</b>	0	90

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
Central DuPage Health System	100.00%			Central Dupage Hosp.	Winfield, IL.	Hospital
				CDH Alcoholic Treat.	Naperville, IL.	Alcoholic Treat
				Community Nursing	Naperville, IL.	In-House Nursing
				Marklund Childrens	Bloomington, IL.	DD Child Home
				Pahes II	Naperville, IL.	X-Ray & Resp.
				Wyndemore Retire	Naperville, IL.	Retire Community

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	10a Therapies - PT, OT, & ST	\$ 69,739	Central Dupage Hospital	0.00%	\$ 69,739	\$ 1
2	V	30 Depreciation Expense		Central Dupage Health System	100.00%	50,522	50,522 2
3	V	17 Management Fee	456,670	Central DuPage Health System	100.00%	641,384	184,714 3
4	V						4
5	V						5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 526,409			\$ 761,645	\$ * 235,236 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Central DuPage Health System  
 Street Address 27 West 353 Jewell Road  
 City / State / Zip Code Winfield, IL 60190  
 Phone Number ( 630 ) 933-5063  
 Fax Number ( 630 ) 933-1728

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	Management Fees	Accum Cost	262,953	8	\$ 1,487,165	\$ 8,933	\$ 50,522	1
2	30	Depreciation	Accum Cost	262,953	8	18,879,881	8,933	641,384	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 20,367,046	\$	\$ 691,906	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Health Care Associates		X	Mortgage	\$60,195.00	1/1/00	\$ 7,029,000	6,998,467	12/31/24	0.0093	\$ 110,760	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Not Applicable											6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$60,195.00		\$ 7,029,000	\$ 6,998,467			\$ 110,760	9								
<b>B. Non-Facility Related*</b>																				
10	Not Applicable							Interest Income Offset			(46,417)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(46,417)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 7,029,000	\$ 6,998,467			\$ 64,343	15								

\* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Wynscape

# 0041426 Report Period Beginning:

7/1/99 Ending:

6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,390 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

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

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

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

1. Total Amount Incurred: N/A 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Patient Care		2000	\$ 1,800,000	1
2					2
3	TOTALS			\$ 1,800,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Wynscape

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Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	209		2000		\$ 5,726,808	\$ 71,586	40	\$ 71,586	\$	\$ 71,586	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Elevator			7/1/1996	2,468		20	123	123	432	9
10	Prior Year Improvement to Facility Project Number 96071			6/30/1997	1,342,163	159,653	40	33,555	(126,098)	151,001	10
11	General Construction Project Number 96007			6/30/1997	154,315		40	3,858	3,858	13,503	11
12	Demolition			6/30/1997	14,620		40	366	366	1,281	12
13	Construction Debris Removal			6/30/1997	18,783		40	470	470	1,645	13
14	Excavation			6/30/1997	4,356		40	109	109	382	14
15	Concrete			6/30/1997	28,710		40	718	718	2,513	15
16	Unit Masonry			6/30/1997	39,480		40	987	987	3,455	16
17	Rough Carpentry			6/30/1997	1,488		40	37	37	130	17
18	Temporary Protection Cleanup			6/30/1997	10,767		40	269	269	942	18
19	Wood Doors			6/30/1997	7,043		40	176	176	616	19
20	Spray on Fire Proofing			6/30/1997	11,800		40	295	295	1,033	20
21	Membrane Roofing			6/30/1997	95,011		40	2,375	2,375	8,313	21
22	Metal Door and Frames			6/30/1997	14,369		40	359	359	1,257	22
23	Wood Replacement Doors			6/30/1997	4,381		40	110	110	385	23
24	Entrances and Storefront			6/30/1997	28,398		40	710	710	2,485	24
25	Aluminum Windows			6/30/1997	127,610		40	3,190	3,190	11,165	25
26	Hardware			6/30/1997	38,367		40	959	959	3,357	26
27	Interior Glazing			6/30/1997	8,750		40	219	219	767	27
28	Drywall			6/30/1997	471,593		40	11,790	11,790	41,265	28
29	Ceramic Tile			6/30/1997	34,909		40	873	873	3,056	29
30	Resilient Flooring			6/30/1997	35,834		40	896	896	3,136	30
31	Floor Prep			6/30/1997	1,809		40	45	45	158	31
32	Painting			6/30/1997	38,007		40	950	950	3,325	32
33	Toilet and Bath Accessories			6/30/1997	20,015		40	500	500	1,750	33
34	Kitchen and Building Allowance			6/30/1997	118,968		40	2,974	2,974	10,409	34
35	Window Treatment Allowance			6/30/1997	19,238		40	481	481	1,684	35
36	TOTAL (lines 4 thru 35)				\$ 8,420,060	\$ 231,239		\$ 138,980	\$ (92,259)	\$ 341,031	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wynscape

# 0041426

Report Period Beginning:

7/1/99

Ending:

6/30/00

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Storage / Moving	6/30/1997		1,748		40	45	45	154	9
10		Final Cleaning Allowance	6/30/1997		11,225		40	281	281	984	10
11		Field Investigation	6/30/1997		900		40	23	23	81	11
12		Fire Protection	6/30/1997		17,701		40	443	443	1,551	12
13		Plumbing	6/30/1997		155,685		40	3,892	3,892	13,622	13
14		HVAC	6/30/1997		24,900		40	623	623	2,181	14
15		Electrical	6/30/1997		322,774		40	8,069	8,069	28,242	15
16		Fire Alarm System	6/30/1997		13,741		40	344	344	1,204	16
17		Premium Time Drywall	6/30/1997		2,366		40	59	59	207	17
18		Reconstruction Fee	6/30/1997		28,000		40	700	700	2,450	18
19		Fees to Schall Brothers	6/30/1997		72,379		40	1,809	1,809	6,332	19
20		Insurance	6/30/1997		17,277		40	432	432	1,512	20
21		Millwork	6/30/1997		61,115	3,581	40	1,528	(2,053)	5,349	21
22		Architect Fees	7/30/1997		150,000	30,000	5	30,000		75,000	22
23		Architectural Reimbursement	7/30/1997		10,952	2,190	5	2,190		5,476	23
24		Survey	7/30/1997		7,956	1,624	5	1,591	(33)	3,978	24
25		City Permits Fees	7/30/1997		4,886	1,243	5	977	(266)	2,443	25
26		Legal (Contract Only)	7/30/1997		6,927	1,385	5	1,385		3,463	26
27		Contingency Fees	7/30/1997		36,385	3,311	10	3,639	328	9,098	27
28		Testing Services	7/30/1997		10,864	2,173	5	2,173		5,432	28
29		Title Insurance	7/30/1997		346		1			346	29
30		Landscaping	7/30/1997		45,000	9,000	5	9,000		22,500	30
31		Fence	7/30/1997		4,287	612	7	612		1,531	31
32		Balance of Landscaping	10/23/1997		15,000	1,500	10	1,500		3,750	32
33		Seal Stripe Parking Lot	10/28/1997		2,950	986	3	983	(3)	2,458	33
34		Elevator Repairs	1/13/1998		11,000		20	550	550	1,375	34
35		Security System	2/3/1998		2,318		10	232	232	580	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 1,038,682	\$ 57,605		\$ 73,080	\$ 15,475	\$ 201,299	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wynscape

# 0041426

Report Period Beginning:

7/1/99

Ending:

6/30/00

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Elevator Repairs		7/1/1998		1,500	500	3	500		1,000	9
10	Elevator Repairs		11/18/1998		7,942	2,647	3	2,647		5,294	10
11	Gas Water Heater		11/10/1998		2,657	886	3	886		1,772	11
12	Smoke Detectors		1/11/1999		2,225	742	3	742		1,484	12
13	Elevator Repairs		1/13/1999		27,293	9,098	3	9,098		18,196	13
14	Elevator Repairs		2/8/1999		6,349	2,116	3	2,116		4,232	14
15	Plumbing Repairs		4/28/1999		700	233	3	233		466	15
16	Rear Door Repairs		5/14/1966		2,799	933	3	933		1,866	16
17	Elevator Repairs		6/30/1999		1,600	533	3	533		1,066	17
18	Elevator Repairs		6/30/1999		15,078	5,026	3	5,026		10,052	18
19	Disposer & wall Heating & Cooling Units		7/1/1998		8,549	2,850	3	2,850		5,700	19
20	Roof Covering and Gutters		1/13/1998		4,345	1,448	3	1,448		3,621	20
21	Toilet Replacement		7/1/1999		12,397	2,066	3	2,066		2,066	21
22	Toilet Replacement		8/1/1999		1,194	199	3	199		199	22
23	Plumbing & Electric Work		7/1/1999		4,100	683	3	683		683	23
24	Elevator Repairs & Electric		7/1/1999		31,402	5,234	3	5,234		5,234	24
25	Sidewalk Repair		7/1/1999		1,892	315	3	315		315	25
26	Door Holders		12/31/1999		4,784	797	3	797		797	26
27	Electrical Panel Repair		12/31/1999		4,900	817	3	817		817	27
28	Nurse Call System		2/29/2000		9,083	1,514	3	1,514		1,514	28
29	Building Improvements		6/30/2000		695,254	8,691	40	8,691		8,691	29
30	Nurse Call System		2/29/2000		54,480	9,080	3	9,080		9,080	30
31	Allocated from Central DuPage Health System							11,443	11,443		31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 900,523	\$ 56,408		\$ 67,851	\$ 11,443	\$ 84,145	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
37	Purchased in Prior Years	\$ 293,946	\$ 65,589	\$ 56,884	\$ (8,705)	3-10 yrs	\$ 343,162	37
38	Current Year Purchases	24,350	1,677	1,677		3-5 yrs	1,677	38
39	Fully Depreciated Assets							39
40	Allocated from Central DuPage Health			39,079	39,079			40
41	TOTALS	\$ 318,296	\$ 67,266	\$ 97,640	\$ 30,374		\$ 344,839	41

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	
42	Resident Transportation	1997 Ford Van Shuttle	1998	\$ 45,524	\$	\$ 11,381	\$ 11,381	4	\$ 27,934	42
43										43
44										44
45										45
46	TOTALS			\$ 45,524	\$	\$ 11,381	\$ 11,381		\$ 27,934	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 12,523,085	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 412,518	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 388,932	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (23,586)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 999,248	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Building Improvements	\$ 238,304	58
59			59
60			60
61		\$ 238,304	61

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wynscape

# 0041426

Report Period Beginning:

7/1/99

Ending: 6/30/00

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Health Care Fund Limited

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1969</u>	<u>209</u>	<u>11/15/84</u>	\$ <u>343,013</u>	<u>15</u>	<u>10</u>	<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6								<u>6</u>
7	<b>TOTAL</b>		<b>209</b>		\$ <b>343,013</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 11/15/84

Ending 11/15/99

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

Fiscal Year Ending                      Annual Rent

12.	<u>/2001</u>	\$ <u>                    </u>
13.	<u>/2002</u>	\$ <u>                    </u>
14.	<u>/2003</u>	\$ <u>                    </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

9. Option to Buy:  YES  NO Terms: \$35,000 per bed after 11/14/99 \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 23,799

Description: Copy Machine, Postage Meter, etc: \$23,524; Activity Equipment: \$275

(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			\$ <u>                    </u>	\$ <u>                    </u>	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	<b>TOTAL</b>		\$ <u>                    </u>	\$ <u>                    </u>	<b>21</b>

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p><i>It is the policy of this facility to only hire certified nurses aides.</i></p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	5						
					Units	Cost					
1	Licensed Occupational Therapist	L10a, C 1,2&3	96	hrs	\$ 2,196		\$ 9,929	\$ 140	96	\$ 12,265	1
2	Licensed Speech and Language Development Therapist	L10a, C 1&3	206	hrs	6,505		9,820		206	16,325	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10a, C 1,2&3	1878	hrs	63,753		49,990	4,950	1,878	118,693	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescripts				197,373		197,373	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): <u>See Schedule 16A</u>						106,650			106,650	13
14	<b>TOTAL</b>				\$ 72,454		\$ 176,389	\$ 202,463	2,180	\$ 451,306	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 657,271	\$ 657,271	1
2 Cash-Patient Deposits	33,315	33,315	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 42,923 )	1,042,789	1,042,789	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	99,832	99,832	6
7 Other Prepaid Expenses	1,144	1,144	7
8 Accounts Receivable (owners or related parties)	246,469	246,469	8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,080,820</b>	<b>\$ 2,080,820</b>	<b>10</b>
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	1,009,556	1,009,556	12
13 Land	1,800,000	1,800,000	13
14 Buildings, at Historical Cost	11,090,788	10,359,265	14
15 Leasehold Improvements, at Historical Cos			15
16 Equipment, at Historical Cost	366,562	363,820	16
17 Accumulated Depreciation (book methods)	(899,106)	(999,248)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	131,757	131,757	19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify): CIF	238,304	238,304	22
23 Other(specify):			23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 13,737,861</b>	<b>\$ 12,903,454</b>	<b>24</b>
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 15,818,681</b>	<b>\$ 14,984,274</b>	<b>25</b>

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 102,378	\$ 102,378	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	219,385	219,385	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)		33,834	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See Attached Schedule 17C	1,480,204	1,480,204	36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,801,967</b>	<b>\$ 1,835,801</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	6,998,467	6,998,467	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 6,998,467</b>	<b>\$ 6,998,467</b>	<b>45</b>
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 8,800,434</b>	<b>\$ 8,834,268</b>	<b>46</b>
47 <b>TOTAL EQUITY</b> (page 18, line 24)	<b>\$ 7,018,247</b>	<b>\$ 6,150,006</b>	<b>47</b>
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 15,818,681</b>	<b>\$ 14,984,274</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>6,266,233</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>6,266,233</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>72,502</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>72,502</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>	<b>Fund Balance Transfer</b>	<b>695,254</b>	<b>18</b>
<b>19</b>	<b>Mkt Appr/Depr- Goldman Combined</b>	<b>(15,742)</b>	<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>679,512</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,018,247</b>	<b>24</b> *

"Operating Entity Only"

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,175,721	1
2	Discounts and Allowances for all Levels	(2,122,415)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,053,306	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	242,228	6
7	Oxygen	16,203	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 258,431	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	296,059	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,698	19
20	Radiology and X-Ray	136,240	20
21	Other Medical Services	24,248	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 479,245	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	46,417	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 46,417	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Attached Schedule 19E	7,087	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,087	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,844,486	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,491,364	31
32	Health Care	3,844,394	32
33	General Administration	1,979,279	33
<b>B. Capital Expense</b>			
34	Ownership	995,090	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	347,115	35
36	Provider Participation Fee	114,742	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,771,984	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	72,502	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 72,502	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. This Entity Files as part of a Consolidated Return

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

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

Facility Name & ID Number Wynscape

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,840	2,160	\$ 53,416	\$ 24.73	1
2	Assistant Director of Nursing	1,936	2,160	43,373	20.08	2
3	Registered Nurses	33,936	36,164	786,384	21.74	3
4	Licensed Practical Nurses	18,025	19,040	337,449	17.72	4
5	Nurse Aides & Orderlies	122,481	129,253	1,569,712	12.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,180	2,325	72,454	31.16	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,160	34,948	16.18	9
10	Activity Assistants	14,765	15,661	139,267	8.89	10
11	Social Service Workers	3,772	4,320	51,814	11.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,907	36,062	420,530	11.66	15
16	Dishwashers					16
17	Maintenance Workers	3,669	3,963	32,451	8.19	17
18	Housekeepers	31,226	33,647	298,407	8.87	18
19	Laundry	11,238	11,740	97,665	8.32	19
20	Administrator	1,872	2,160	81,004	37.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,028	23,778	308,904	12.99	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	1,775	1,878	21,250	11.32	31
32	Other Health Care(Supply Clerk)	1,519	1,612	16,416	10.18	32
33	Other(specify) Nursing Admin	13,570	14,861	297,662	20.03	33
34	TOTAL (lines 1 - 33)	321,691	342,944	\$ 4,663,106 *	\$ 13.60	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	138	\$ 5,256	L1, C3	35
36	Medical Director	Monthly	31,025	L9, C3	36
37	Medical Records Consultant	22	1,015	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	3,335	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	235	\$ 40,631		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See instructions.

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janis Ormond	Administrator	0.00%	\$ 81,004	Workers' Compensation Insurance	\$ 101,952	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	26,740	
				FICA Taxes	333,507	Health Care Worker Background Check		
				Employee Health Insurance	288,312	(Indicate # of checks performed 175 )	2,100	
				Employee Meals		Various Dues and Subscriptions	1,720	
				Illinois Municipal Retirement Fund (IMRF)*		HCFA Laboratory Fee	150	
				Life Insurance	20,529	Dietary License	500	
				Pension	57,053	Administration	249	
				Employee Relations	9,759	Various Fees and Licenses	201	
				Employee Physical	19,731			
				Bonus Pay	105,162	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,004	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 936,005		\$ 31,660		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Central DuPage Health System - Management Fees Eliminated in Col. 7			\$ 456,670				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 456,670				In-State Travel	805
C. Professional Services								
Vendor/Payee	Type		Amount				Seminar Expense	1,569
American Express TBS	Accounting		\$ 9,463					
Altschuler, Melvoin, & Glasser, LLP	Accounting		9,194				Entertainment Expense	( )
KPMG,LLP	Accounting		3,500				(agree to Sch. V, line 24, col. 8)	
Katten, Muchin & Zavis	Legal		6,992				TOTAL	\$ 2,374
Fenech & Pachulski, P.C.	Legal		14,425					
Julie Najawicz	Interior Design		920					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 44,494	TOTAL		\$		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Wynscape

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	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
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20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Wynscape

# 0041426

Report Period Beginning: 7/1/99

Ending: 6/30/00

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political 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? 4.84 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,640 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ 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 of Public Aid during this cost report period. \$ 114,742  
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 of Public Aid, 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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? N/A  
d. Have vehicle usage logs been maintained? Yes  
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? Yes  
Firm Name: KPMG, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Will be mailed upon completion
- (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 \$2500, 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**