

Facility Name & ID Number Winfield Woods

0045898 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

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 8/1/02

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	135	Intermediate (ICF)	135	49,275	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	41,304	4,685	243	46,232	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,304	4,685	243	46,232	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 93.82%

D. How many bed-hold days during this year were paid by Public Aid?

575 (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)

N/A

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/2002 NO

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

STATE OF ILLINOIS

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Facility Name & ID Number Winfield Woods # 0045898 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

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
A. General Services											
1	Dietary	156,729	19,140	8,150	184,019		184,019		184,019		1
2	Food Purchase		206,791		206,791	(7,500)	199,291	(165)	199,126		2
3	Housekeeping	279,299	40,629		319,928		319,928		319,928		3
4	Laundry	19,684	14,499	618	34,801		34,801		34,801		4
5	Heat and Other Utilities			126,709	126,709		126,709		126,709		5
6	Maintenance	25,488	12,759	187,441	225,688		225,688	(46,257)	179,431		6
7	Other (specify):*										7
8	TOTAL General Services	481,200	293,818	322,918	1,097,936	(7,500)	1,090,436	(46,422)	1,044,014		8
B. Health Care and Programs											
9	Medical Director			1,625	1,625		1,625		1,625		9
10	Nursing and Medical Records	1,181,417	54,704	32,898	1,269,019		1,269,019		1,269,019		10
10a	Therapy			4,010	4,010		4,010		4,010		10a
11	Activities	95,113	4,461		99,574		99,574		99,574		11
12	Social Services	145,871	6,200		152,071		152,071		152,071		12
13	Nurse Aide Training										13
14	Program Transportation		1,309		1,309		1,309		1,309		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,422,401	66,674	38,533	1,527,608		1,527,608		1,527,608		16
C. General Administration											
17	Administrative	41,093			41,093		41,093		41,093		17
18	Directors Fees										18
19	Professional Services			73,357	73,357		73,357		73,357		19
20	Dues, Fees, Subscriptions & Promotion			26,169	26,169		26,169	(7,100)	19,069		20
21	Clerical & General Office Expense	103,393	9,444	75,407	188,244		188,244		188,244		21
22	Employee Benefits & Payroll Tax			383,897	383,897	7,500	391,397		391,397		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,398	3,398		3,398	(122)	3,276		24
25	Other Admin. Staff Transportation			6,371	6,371		6,371		6,371		25
26	Insurance-Prop.Liab.Malpractice			54,660	54,660		54,660		54,660		26
27	Other (specify):*										27
28	TOTAL General Administration	144,486	9,444	623,259	777,189	7,500	784,689	(7,222)	777,467		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,048,087	369,936	984,710	3,402,733		3,402,733	(53,644)	3,349,089		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 Winfield Woods

#0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
	D. Ownership											
30	Depreciation			20,744	20,744		20,744	338,341	359,085			30
31	Amortization of Pre-Op. & Org							6,979	6,979			31
32	Interest			35,013	35,013		35,013	246,702	281,715			32
33	Real Estate Taxes							54,945	54,945			33
34	Rent-Facility & Grounds			813,146	813,146		813,146	(813,146)				34
35	Rent-Equipment & Vehicle:			23,146	23,146		23,146		23,146			35
36	Other (specify): ³											36
37	TOTAL Ownership			892,049	892,049		892,049	(166,179)	725,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatio											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			73,913	73,913		73,913		73,913			42
43	Other (specify): ³											43
44	TOTAL Special Cost Centers			73,913	73,913		73,913		73,913			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,048,087	369,936	1,950,672	4,368,695		4,368,695	(219,823)	4,148,872			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 Winfield Woods

0045898

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

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 Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	191,762	30		9
10	Interest and Other Investment Incom	(829)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	2		13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(122)	24		19
20	Contributions	(2,362)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(2,831)	20		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 185,453		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 185,453		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			\$		38
39						39
40	Gift and Coffee Shop:					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Winfield Woods

ID# 0045898

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Capitalized Repairs & Maintenance	\$ (46,257)	6	1
2	ICLTC (COPE)	(1,907)	20	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	(48,164)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	(165)	0	0	0	0	0	0	0	0	0	0	(165)	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	(46,257)	0	0	0	0	0	0	0	0	0	0	(46,257)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(46,422)	0	0	0	0	0	0	0	0	0	0	(46,422)	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	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,100)	0	0	0	0	0	0	0	0	0	0	(7,100)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(122)	0	0	0	0	0	0	0	0	0	0	(122)	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	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,222)	0	0	0	0	0	0	0	0	0	0	(7,222)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,644)	0	0	0	0	0	0	0	0	0	0	(53,644)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Winfield Woods**# **0045898**

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	191,762	146,579	0	0	0	0	0	0	0	0	0	338,341 30
31	Amortization of Pre-Op. & Org.	0	6,979	0	0	0	0	0	0	0	0	0	6,979 31
32	Interest	(829)	247,531	0	0	0	0	0	0	0	0	0	246,702 32
33	Real Estate Taxes	0	54,945	0	0	0	0	0	0	0	0	0	54,945 33
34	Rent-Facility & Grounds	0	(813,146)	0	0	0	0	0	0	0	0	0	(813,146) 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	190,933	(357,112)	0	(166,179) 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)	137,289	(357,112)	0	(219,823) 45								

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
Susan Simonsen	50.0%	Lydia Healthcare	Robbins	Winfield Building LLC		Landlord-related
William Daugherty	50.0%			Winfield Woods Healthcare LLC		Former Operating Entity - related

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	34 Rental Income	\$ 813,146	Winfield Building LLC	100.00%	\$	\$ (813,146)	1
2	V	30 Depreciation		Winfield Building LLC	100.00%	146,579	146,579	2
3	V	31 Amortization		Winfield Building LLC	100.00%	6,979	6,979	3
4	V	32 Interest Expense		Winfield Building LLC	100.00%	278,374	278,374	4
5	V	33 Real Estate Taxes		Winfield Building LLC	100.00%	54,945	54,945	5
6	V							6
7	V							7
8	V	32 Interest Expense	30,843	Winfield Healthcare LLC	100.00%		(30,843)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 843,989			\$ 486,877	\$ * (357,112)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Winfield Woods # 0045898 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

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	Susan Simonsen	Owner	Administrative	50.0%	See Attached	40	80.0%		\$	1
2	William Daugherty	Owner	Administrative	50.0%	See Attached	10	20.0%			2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Winfield Woods # 0045898 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

Facility Name & ID Number Winfield Woods # 0045898 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

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		8	9	10		
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Bank One (American National Bank)	X		Mortgage	\$39,695.00	12/9/98	\$ 5,200,000	\$ None			\$ 278,374	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American Chartered Bank		X	Line of Credit			50,000	50,000			3,766	6
7	Working Capital Loan	X		Acquisition Financing			837,026	650,067			30,843	7
8	Citi Card			Credit Card							404	8
9	TOTAL Facility Related				\$39,695.00		\$ 6,087,026	\$ 700,067			\$ 313,387	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income										(829)	12
13	Interest Income - prior Operating Entity										(30,843)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (31,672)	14
15	TOTALS (line 9+line14)						\$ 6,087,026	\$ 700,067			\$ 281,715	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winfield Woods COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0045898

CONTACT PERSON REGARDING THIS REPORT Susan Simonsen

TELEPHONE (630) 668 - 9696 FAX #: (630) 668 - 7078

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-14-201-003</u>	<u>Nursing Home</u>	\$ <u>50,412.24</u>	\$ <u>50,412.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>50,412.24</u>	\$ <u>50,412.24</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Winfield Woods

0045898 Report Period Beginning:

1/1/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,991 B. General Construction Type: Exterior Brick Frame Brick Number of Stories Two

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

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: \$ 16,751 - Financing Costs 2. Number of Years Over Which it is Being Amortized 7
3. Current Period Amortization: \$ 6,980 - (Debt paid off early in 2003) 4. Dates Incurred: 1998

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	Facility	20,991		\$ 276,000	1
2					2
3	TOTALS	20,991		\$ 276,000	3

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			1996	\$ 3,001,500	\$ 76,962	20	\$ 150,075	\$ 73,113	\$ 1,113,056	4
5										5
6										6
7										7
8										8
Improvement Type**										
9			1996	19,219		20	963	963	6,941	9
10			1997	1,556,040		20	77,804	77,804	536,478	10
11			1998	351,210		20	17,561	17,561	100,166	11
12										12
13										13
14										14
15										15
16										16
17										17
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21										21
22										22
23										23
24										24
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29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Financial Statement depreciation - Building			52,640			(52,640)		68
69	Financial Statement depreciation - Operation			1,424			(1,424)		69
70	TOTAL (lines 4 thru 69)		\$ 4,927,969	\$ 131,026		\$ 246,403	\$ 115,377	\$ 1,756,641	70

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,927,969	\$ 131,026		\$ 246,403	\$ 115,377	\$ 1,756,641		1
2	REPAIRS 1ST FLOOR	1999 5,815		20	291	291	1,431		2
3	ELEVATOR REPAIRS	1999 1,625		20	81	81	385		3
4	TOILET KIT	1999 1,130		20	57	57	271		4
5	1ST FLOOR REPAIRS	1999 1,449		20	72	72	348		5
6	HVAC REPAIRS	1999 1,106		20	55	55	252		6
7	HVAC REPAIRS	1999 1,029		20	51	51	234		7
8	LUMBER	1999 1,784		20	89	89	415		8
9	BLINDS	1999 2,079		20	104	104	433		9
10	SPRINKLER SYSTEM	1999 6,550		20	328	328	1,339		10
11	BLINDS	1999		20					11
12	ROBERTS	1999 32,181		20	1,609	1,609	6,704		12
13	HVAC REPAIRS	1999		20					13
14	TRICOM-WIRING	1999 1,286		20	64	64	283		14
15	ROBERTS	1999 2,890		20	145	145	616		15
16	PLUMBING	1999 1,934		20	97	97	388		16
17	OLYMPIC SIGNS	1999 581		20	29	29	116		17
18	CORNICE & BLINDS INS	2000 1,294		20	65	65	260		18
19	BLINDS FREIGHT	2000 55		20	3	3	12		19
20	IDPH PERMIT FEE	2000 5,760		20	288	288	1,080		20
21	SEALCOATING & STRIPE	2000 3,998		20	200	200	733		21
22	GAS LEAK REPAIR	2000 582		20	29	29	116		22
23	ELECTRIC WORK	2000 606		20	30	30	120		23
24	GLASS/FRAME INST	2000 700		20	35	35	134		24
25	WINDOW INSTALLATION	2000 790		20	40	40	153		25
26	A/C REPAIR	2000 516		20	26	26	98		26
27	W/I FREEZER REPAIR	2000 535		20	27	27	101		27
28	PLUMBING	2000 920		20	46	46	150		28
29	CABLE & JACK INST	2000 940		20	47	47	145		29
30	COUNTER TOP INST	2000 500		20	25	25	77		30
31	PLUMBING	2000 11,715		20	586	586	2,295		31
32	VENTILATION	2000 2,898		20	145	145	568		32
33	PLUMBING	2000 1,869		20	93	93	349		33
34	TOTAL (lines 1 thru 33)	\$ 5,023,086	\$ 131,026		\$ 251,160	\$ 120,134	\$ 1,776,247		34

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,023,086	\$ 131,026		\$ 251,160	\$ 120,134	\$ 1,776,247	1
2	REMODELING	2000	1700		20	85	85	326	2
3	REMODELING	2000	1700		20	85	85	326	3
4	A/C TEST & BALANCE	2000	8500		20	714	714	2,788	4
5	SPRINKLER INST	2000	3000		20	150	150	475	5
6	SHELVES INSTALLATION	2000	600		20	30	30	95	6
7	FIRE DOOR	2000	2100		20	105	105	385	7
8	FLOORING	2000	2100		20	105	105	385	8
9	BLDG DEMOLITION	2000	13500		20	675	675	2,138	9
10	BORDER	2001	3276		20	164	164	465	10
11	BORDER,COVE BASE	2001	714		20	36	36	102	11
12	BORDER	2001	1013		20	51	51	140	12
13	BORDER INS	2001	2208		20	110	110	303	13
14	COVE BASE,WINDOW,CHA	2001	2701		20	135	135	383	14
15	WALLPAPER	2001	162		20	8	8	23	15
16	WALLPAPER,BORDER,COV	2001	2726		20	136	136	385	16
17	CORNER PIECE	2001	638		20	32	32	85	17
18	WALLPAPER	2001	525		20	26	26	69	18
19	BORDER	2001	263		20	13	13	35	19
20	BORDER	2001	89		20	4	4	11	20
21	WALLPAPER	2001	491		20	25	25	71	21
22	BORDER	2001	156		20	8	8	20	22
23	BORDER INSTALL	2001	415		20	21	21	53	23
24	LABOR STRIP	2001	667		20	33	33	83	24
25	LABOR - BORDER,STRIP	2001	1357		20	68	68	170	25
26	WALL BUMPERS	2001	331		20	17	17	41	26
27	CARPET	2001	5087		20	254	254	572	27
28	CARPETING	2001	1441		20	72	72	162	28
29	COVE BASE	2001	524		20	26	26	56	29
30	FLOOR PATCH	2001	170		20	9	9	20	30
31	ROSEWOOD WING CORRID	2001	15186		20	759	759	1,581	31
32	CONSTRUCTION	2001	2415		20	121	121	262	32
33	CONDENSOR MOTOR	2001	688		20	34	34	91	33
34	TOTAL (lines 1 thru 33)		\$ 5,099,529	\$ 131,026		\$ 255,271	\$ 124,245	\$ 1,788,348	34

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,099,529	\$ 131,026		\$ 255,271	\$ 124,245	\$ 1,788,348	1
2	ALARM INSTALLATION	2001	7073		20	354	354	1,062	2
3	HVAC	2001	7547		20	377	377	1,100	3
4	SPRINKLERS INSTALL	2001	37000		20	1850	1,850	5,550	4
5	PLUMBING & SEWER WOR	2001	5089		20	254	254	720	5
6	ELEC LABOR & MATERIA	2001	1250		20	63	63	173	6
7	CARY SUPPLY	2001	1810		20	91	91	243	7
8	SPRINKLERS	2001	16250		20	813	813	2,304	8
9	PLUMBING	2001	1756		20	88	88	235	9
10	A/C WORK	2001	9543		20	477	477	1,232	10
11	5 EXHAUST FAN BRACKE	2001	1163		20	58	58	126	11
12	EXHAUST FAN MOTORS	2001	1402		20	70	70	152	12
13	BLOWER MOTORS	2001	1481		20	74	74	160	13
14	BORDER	2001	5476		20	274	274	822	14
15	LAUNDRY RM EXHAUST F	2001	2930		20	147	147	306	15
16	CYLINDER CORES	2001	833		20	42	42	126	16
17	ALARM INSTALLATION	2001	7155		20	358	358	1,074	17
18	HEATING/AIRCONDITION	2001	36000		20	1800	1,800	5,250	18
19	BORDER INS	2001	1725		20	86	86	229	19
20	TEST & BALANCE ENV.	2001	8500		20	425	425	956	20
21	DUCT REVISION	2001	6500		20	325	325	731	21
22	THERMOSTATS	2001	765		20	38	38	111	22
23	WRIGHT ELECTRIC	2001	500		20	25	25	73	23
24	PLUMBING & SEWER	2001	676		20	34	34	94	24
25	PLUMBING & SEWER	2001	717		20	36	36	87	25
26	MOTOR	2001	925		20	46	46	107	26
27	MOTOR	2001	703		20	35	35	82	27
28	NETWORKING SOLUTIONS	2001	813		20	41	41	85	28
29	WALLPAPER	2001	655		20	33	33	69	29
30	HEATING IMPROVEMENT	2001	532		20	27	27	56	30
31	ELEVATOR	2001	6600		20	330	330	935	31
32	WRIGHT ELECTRIC	2001	500		20	25	25	73	32
33	ELEVATOR RENOVATION	2001	1455		20	73	73	195	33
34	TOTAL (lines 1 thru 33)		\$ 5,274,853	\$ 131,026		\$ 264,040	\$ 133,014	\$ 1,812,866	34

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,274,853	\$ 131,026		\$ 264,040	\$ 133,014	\$ 1,812,866	1
2	WALLCOVERING	2002	3,300		20	165	165	330	2
3	CONFERENCE ROOM DOORS REPAIR	2002	10,000		20	1000	1,000	2,000	3
4	DUCT WORK	2002	17,500		20	1167	1,167	2,334	4
5	CONCRETE,SLOPE TERRACES & SIDEWALKS	2002	5,450		20	273	273	546	5
6	WIRING REPAIR	2002	931		20	47	47	94	6
7	WALLPAPER INSTALLATION	2002	1,506		20	1506	1,506	3,012	7
8	REVISIONS OF MECHANICAL DRAWINGS	2002	967		20	48	48	96	8
9	PVC CORNER GUARD,PEWTER	2002	707		20	29	29	58	9
10	NO COOLING	2002	681		20	68	68	136	10
11	ADJUST OUTDOOR AIR	2002	1,547		20	103	103	206	11
12	CHECKED FIRE SYSTEM	2002	452		20	30	30	60	12
13	GENERATOR REPAIR & SERVICE	2002	637		20	42	42	84	13
14	NEW PARTS FOR MENS SHOWER	2002	510		20	4	4	8	14
15	INSTALL WINDOW A/C UNITS	2002	609		20	10	10	20	15
16	60 LAMPS	2002	2,144		20	107	107	214	16
17	BORDER PAPER INSTALLATION	2002	2,875		20	2875	2,875	5,750	17
18	PVC CORNER GUARD,HAND RAIL,PEDESTAL TABLE BASE	2002	1,269		20	212	212	424	18
19	NEW PARKING AREA	2002	3,645		20	106	106	212	19
20	GAZEBO FOUNDATION,FRAMING & LANDSCAPING	2002	9,858		20	657	657	1,314	20
21	BLOWER MOTOR REPAIR	2002	1,107		20	38	38	76	21
22	CABLE WIRING	2002	4,550		20	379	379	758	22
23	CONFERENCE ROOM DOOR REPAIRS	2002	2,701		20	11	11	22	23
24	GENERATOR	2003	16,068		20	803	803	803	24
25	GENERATOR INSTALLATION	2003	14,350		20	718	718	718	25
26	CABINETS	2003	8,840		20	442	442	442	26
27	BAR TOP	2003	4,880		20	244	244	244	27
28	MIRRORS	2003	3,934		20	197	197	197	28
29	PAVING	2003	32,760		20	1,638	1,638	1,638	29
30	FLOORING	2003	1,065		20	53	53	53	30
31	CARPETING	2003	2,675		20	134	134	134	31
32	BUILDING IMPROVEMENTS	2003	890		20	45	45	45	32
33	BUILDING IMPROVEMENTS	2003	1,558		20	78	78	78	33
34	TOTAL (lines 1 thru 33)		\$ 5,434,819	\$ 131,026		\$ 277,269	\$ 146,243	\$ 1,834,972	34

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,434,819	\$ 131,026		\$ 277,269	\$ 146,243	\$ 1,834,972	1
2	DOOR IMPROVEMENTS	2003	718		20	36	36	36	2
3	BUILDING IMPROVEMENTS	2003	887		20	44	44	44	3
4	BUILDING IMPROVEMENTS	2003	522		20	26	26	26	4
5	WALLCOVERING	2003	2,517		20	126	126	126	5
6	PAINT & WALLCOVERING	2003	4,284		20	214	214	214	6
7	VARNISH DOORS & MOLDINGS	2003	11,121		20	556	556	556	7
8	WALLCOVERING	2003	5,702		20	285	285	285	8
9	WALLCOVERING	2003	526		20	26	26	26	9
10	WALLCOVERING	2003	983		20	49	49	49	10
11	WALLCOVERING	2003	5,868		20	293	293	293	11
12	VARNISH DOORS & MOLDINGS	2003	7,385		20	369	369	369	12
13	WALLCOVERING	2003	7,104		20	355	355	355	13
14	WALLCOVERING & MOLDINGS	2003	8,415		20	421	421	421	14
15	WALLCOVERING	2003	5,846		20	292	292	292	15
16	WALLCOVERING & MOLDINGS	2003	7,060		20	353	353	353	16
17	WATER HEATERS	2003	11,040		20	552	552	552	17
18	AIR RETURN	2003	609		20	30	30	30	18
19	AIR REGISTERS	2003	833		20	42	42	42	19
20	INDUCER MOTOR	2003	695		20	35	35	35	20
21	ELECTRICAL WORK	2003	661		20	33	33	33	21
22	SERVICE DOOR	2003	818		20	41	41	41	22
23	TOUCH PANEL	2003	951		20	48	48	48	23
24	EMERGENCY TELEPHONE SYSTEM-ELEVATOR	2003	883		20	44	44	44	24
25	GENERATOR INSTALLATION	2003	1,400		20	70	70	70	25
26	CARPETING	2003	2,250		20	113	113	113	26
27	BUILDING IMPROVEMENTS	2003	2,705		20	135	135	135	27
28	WALLS, DOORS, CEILING	2003	8,777		20	439	439	439	28
29	WALLS, DOORS, CEILING	2003	2,850		20	143	143	143	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,538,229	\$ 131,026		\$ 282,439	\$ 151,413	\$ 1,840,142	34

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 609,244	\$ 17,421	\$ 60,267	\$ 42,846	10	\$ 438,228	71
72	Current Year Purchases	119,705	8,737	5,987	(2,750)	10	5,987	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 728,949	\$ 26,158	\$ 66,254	\$ 40,096		\$ 444,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	99 Chevy Van	1999	\$ 27,374	\$ 1,775	\$ 1,775	\$	5	\$ 14,560	76
77	Facility	Saturn	2001	5,760	1,106	1,152	46	5	1,776	77
78	Facility	2003 KIA	2002	28,526	5,498	5,705	207	5	6,775	78
79	Facility	2003 Chevy	2003	17,600	1,760	1,760		5	1,760	79
80	TOTALS			\$ 79,260	\$ 10,139	\$ 10,392	\$ 253		\$ 24,871	80

E. Summary of Care-Related Asset

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,622,438	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,323	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 359,085	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 191,762	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,309,228	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-Progres

	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 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</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 _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 6,022 Description: Water Conditioning \$ 1,377; Empire Cooler \$ 1,170; Plant rental \$ 3,475
 (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>02 Mercedes</u>	\$ _____	\$ <u>12,762</u>	17
18		<u>GMAC Van</u>		<u>4,362</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>17,124</u>	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.

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 type="checkbox"/> NO</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$			\$		1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$	\$		\$		\$		\$	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 88,362	\$ 88,362	1
2	Cash-Patient Deposits	33,559	33,559	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	785,556	785,556	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,702	29,702	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	37,944	37,944	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 975,123	\$ 975,123	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	37,379	5,392,653	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	260,186	716,550	16
17	Accumulated Depreciation (book methods)	(42,909)	(1,381,204)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 254,656	\$ 4,727,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,229,779	\$ 5,703,122	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 554,827	\$ 554,827	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,559	59,559	28
29	Short-Term Notes Payable	588,288		29
30	Accrued Salaries Payable	18,328	18,328	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,503	1,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)		52,933	32
33	Accrued Interest Payable	2,451		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)	\$ 1,224,956	\$ 687,150	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)				
46		\$ 1,224,956	\$ 687,150	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,823	\$ 5,015,972	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)				
48		\$ 1,229,779	\$ 5,703,122	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,123,117	1
2	Restatements (describe):		2
3	Equity of entities shown last year as operating;		3
4	presented this year as consolidated	(992,736)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 130,381	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(5,558)	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 Owner:	(120,000)	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)	\$ (125,558)	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)	\$ 4,823	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. 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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,358,238	1
2	Discounts and Allowances for all Level	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,358,238	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		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		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	829	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 829	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		4,070	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,070	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,363,137	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,097,936	31
32	Health Care	1,527,608	32
33	General Administrator	777,189	33
B. Capital Expense			
34	Ownership	892,049	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	73,913	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,368,695	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,558)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,558)	43

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

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

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

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

Facility Name & ID Number Winfield Woods

0045898

Report Period Beginning: 1/1/2003

Ending:

12/31/2003

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	1,848	1,992	\$ 45,819	\$ 23.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,650	12,391	265,742	21.45	3
4	Licensed Practical Nurses	13,521	14,459	305,052	21.10	4
5	Nurse Aides & Orderlies	42,888	43,781	527,796	12.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,072	8,741	95,824	10.96	10
11	Social Service Worker	10,810	11,950	146,938	12.30	11
12	Dietician					12
13	Food Service Supervisor	1,940	2,130	27,006	12.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,701	15,946	133,625	8.38	15
16	Dishwashers					16
17	Maintenance Worker	2,082	2,139	26,739	12.50	17
18	Housekeepers	30,122	32,902	282,949	8.60	18
19	Laundry	2,057	2,310	17,169	7.43	19
20	Administrator					20
21	Assistant Administrator	2,732	2,904	39,740	13.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,539	9,834	105,629	10.74	24
25	Vocational Instructor					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	2,288	2,488	28,059	11.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,250	163,967	\$ 2,048,087 *	\$ 12.49	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 8,150	01-03	35
36	Medical Director	Monthly 1,625	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant	738	10-03	38
39	Pharmacist Consultant	Monthly 5,365	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Dental Consultant	2,700	10-03	47
48	Psychosocial Consultant	4,010	10a-3	48
49	TOTAL (lines 35 - 48)	\$ 22,588		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses			51	
52	Nurse Aides	1,205	24,095	10-03	52
53	TOTAL (lines 50 - 52)	1,205	\$ 24,095		53

Facility Name & ID Number Winfield Woods# 0045898Report Period Beginning: 1/1/2003Ending: 12/31/2003**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union Yes
- (2) Are there any dues to nursing home associations included on the cost report Yes
If YES, give association name and amount ICLTC - \$ 7,948
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. N/A Line _____
- (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 _____
- (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 X NO _____ If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over
Winfield Healthcare Center
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 73,913
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 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? No
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,500 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 program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in Ln
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain 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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____

March 1, 2004

To Whom It May Concern:

Please be advised that the amount of auto and travel expenses listed below is reimbursed for Winfield Healthcare personnel when traveling from Winfield Healthcare to Lydia Healthcare. This amount is for gas only.

Auto & Travel Expenses	xxxxxx
------------------------	--------

I trust that the above information is helpful.

Susan Simonsen
Owner

Chip Daugherty
Owner

SUSAN SIMONSEN
 AVERAGE HOURS WORKED
 AND COMPENSATION
 1/1/2003 THROUGH 12/31/2003

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
LYDIA HC	10			\$ -
WINFIELD	40			-
	50	\$ -	\$ -	\$ -

WILLIAM DAUGHERTY
 AVERAGE HOURS WORKED
 AND COMPENSATION
 1/1/2003 THROUGH 12/31/2003

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
LYDIA HC	40			\$ -
WINFIELD	10			-
	50	\$ -	\$ -	\$ -

