



Facility Name & ID Number Winchester House# 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

## 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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>360</u>	Skilled (SNF)	<u>360</u>	<u>131,400</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>360</u>	TOTALS	<u>360</u>	<u>131,400</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,389</u>	<u>780</u>	<u>6,665</u>	<u>20,834</u>	8
9	SNF/PED					9
10	ICF	<u>64,202</u>	<u>11,041</u>		<u>75,243</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>77,591</u>	<u>11,821</u>	<u>6,665</u>	<u>96,077</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 73.12%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Employee Meals, Non-Resident Laundry, Adult Day CareF. Does the facility maintain a daily midnight census? YesG. 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 1941

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter numberof beds certified 46 and days of care provided 6,665Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 11/30/05 Fiscal Year: 11/30/05

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

**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>A. General Services</b>										
1	Dietary	1,075,585	55,480		1,131,065		1,131,065		1,131,065		1
2	Food Purchase		458,330		458,330		458,330	(11,390)	446,940		2
3	Housekeeping	478,550	54,497	7,453	540,500		540,500		540,500		3
4	Laundry	228,819	59,116	421	288,356		288,356	(13,605)	274,751		4
5	Heat and Other Utilities			669,164	669,164		669,164		669,164		5
6	Maintenance	474,209	118,145	85,156	677,510		677,510	(185,983)	491,527		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	2,257,163	745,568	762,194	3,764,925		3,764,925	(210,978)	3,553,947		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,966	18,966		18,966		18,966		9
10	Nursing and Medical Records	7,444,302	603,301	424,183	8,471,786		8,471,786		8,471,786		10
10a	Therapy	356,382	1,563		357,945		357,945		357,945		10a
11	Activities	439,427	13,706	2,100	455,233		455,233		455,233		11
12	Social Services	148,065	247	2,508	150,820		150,820		150,820		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	8,388,176	618,817	447,757	9,454,750		9,454,750		9,454,750		16
	<b>C. General Administration</b>										
17	Administrative	124,498			124,498		124,498		124,498		17
18	Directors Fees										18
19	Professional Services			87,217	87,217		87,217		87,217		19
20	Dues, Fees, Subscriptions & Promotions			46,456	46,456		46,456	(20,018)	26,438		20
21	Clerical & General Office Expenses	547,413	60,112	1,814,063	2,421,588		2,421,588	(2,478)	2,419,110		21
22	Employee Benefits & Payroll Taxes			3,920,443	3,920,443		3,920,443	443,962	4,364,405		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,878	6,878		6,878	(2,303)	4,575		24
25	Other Admin. Staff Transportation			3,227	3,227		3,227		3,227		25
26	Insurance-Prop.Liab.Malpractice							123,408	123,408		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	671,911	60,112	5,878,284	6,610,307		6,610,307	542,571	7,152,878		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	11,317,250	1,424,497	7,088,235	19,829,982		19,829,982	331,593	20,161,575		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.

Schedule of Other Admin. Staff Transportation

Auto Expense: Winchester House	\$3,227
Auto Expense: Related Parties - See Page 6	0
Auto Expense: Page 5 and 5A Adjustments	0
Auto Expense: Total	<u><u>\$3,227</u></u>

Facility Name & ID Number Winchester House

#0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation							707,917	707,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,787	10,787		10,787		10,787			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			10,787	10,787		10,787	707,917	718,704			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			254,629	254,629		254,629		254,629			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							197,100	197,100			42
43	Other (specify):*	16,625			16,625		16,625	(9,276)	7,349			43
44	<b>TOTAL Special Cost Centers</b>	16,625		254,629	271,254		271,254	187,824	459,078			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	11,333,875	1,424,497	7,353,651	20,112,023		20,112,023	1,227,334	21,339,357			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 Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	(11,390)	02		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	(13,605)	04		8
9	Non-Straightline Depreciation	707,917	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,720)	20		28
29	Other-Attach Schedule	(2,940)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 659,964		\$	30

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)	567,370	22	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 567,370		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,227,334		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 Shops					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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Winchester House

ID# 0010678

Report Period Beginning: 12/01/05

Ending: 11/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. Income	\$ (2,478)	21	1
2	Bed Tax (Not in GL)	197,100	42	2
3	Capitalized Repairs and Maintenance	(104,831)	06	3
4	Non-Allowable Seminar	(2,303)	24	4
5	Adult Day Care Expenses	(282)	43	5
6	Adult Day Care Salaries	(8,994)	43	6
7	To Capitalize Current Year Asset Additions	(81,152)	06	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	<b>Total</b>	(2,940)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,390)	0	0	0	0	0	0	0	0	0	0	(11,390)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(13,605)	0	0	0	0	0	0	0	0	0	0	(13,605)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(185,983)	0	0	0	0	0	0	0	0	0	0	(185,983)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(210,978)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(210,978)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(20,018)	0	0	0	0	0	0	0	0	0	0	(20,018)	20
21	Clerical & General Office Expenses	(2,478)	0	0	0	0	0	0	0	0	0	0	(2,478)	21
22	Employee Benefits & Payroll Taxes		443,962	0	0	0	0	0	0	0	0	0	443,962	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,303)	0	0	0	0	0	0	0	0	0	0	(2,303)	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	123,408	0	0	0	0	0	0	0	0	0	123,408	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(24,799)</b>	<b>567,370</b>	<b>0</b>	<b>542,571</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(235,777)</b>	<b>567,370</b>	<b>0</b>	<b>331,593</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

Summary B

11/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	707,917	0	0	0	0	0	0	0	0	0	0	707,917	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>707,917</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>707,917</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	197,100	0	0	0	0	0	0	0	0	0	0	197,100	42
43	Other (specify):*	(9,276)	0	0	0	0	0	0	0	0	0	0	(9,276)	43
44	<b>TOTAL Special Cost Centers</b>	<b>187,824</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>187,824</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>659,964</b>	<b>567,370</b>	<b>0</b>	<b>1,227,334</b>	<b>45</b>								

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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
County of Lake	100					
See Attached List of Board Members						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22 Unemployment Compensation	\$	County of Lake	100.00%	\$ 41,580	\$ 41,580	1
2	V	22 Worker's Compensation		County of Lake	100.00%	390,766	390,766	2
3	V	22 FICA	878,258	County of Lake	100.00%	878,258		3
4	V	22 IMRF	1,129,250	County of Lake	100.00%	1,129,250		4
5	V	21 Indirect A & G Cost Allocation	1,140,102	County of Lake	100.00%	1,140,102		5
6	V	26 Liability Insurance		County of Lake	100.00%	123,408	123,408	6
7	V	22 Health-Life-Dental Insurance	1,912,935	County of Lake	100.00%	1,912,935		7
8	V	22 Employee Physicals		County of Lake	100.00%	10,318	10,318	8
9	V	22 Employee Relations		County of Lake	100.00%	1,298	1,298	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 5,060,545			\$ 5,627,915	\$ * 567,370	14

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

Lake County Board Members

District 1	Judy Martini
District 2	Randall Whitmore
District 3	Suzi Schmidt
District 4	Brent Paxton
District 5	Bonnie Thomson Carter
District 6	Larry Leafblad
District 7	Steve Carlson
District 8	Robert Sabonjian
District 9	Mary Ross Cunningham
District 10	Diana O'Kelly
District 11	Terese Douglass
District 12	Angelo D. Kyle
District 13	Susan Loving Gravenhorst
District 14	Audrey Nixon
District 15	Carol Calabresa
District 16	Robert E. (Bob) Powers
District 17	Stevenson Mountsier
District 18	Pamela O. Newton
District 19	Michael Talbett
District 20	David B. Stolman
District 21	Ann B. Maine
District 22	Carol Spielman
District 23	Anne Flanigan Bassi

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Winchester House

# 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Winchester House # 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.)

Facility Name & ID Number Winchester House# 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

## NOTES:

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Winchester House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0010678

CONTACT PERSON REGARDING THIS REPORT Mary T. Stevens

TELEPHONE 847-377-7236 FAX #: 847-816-5168

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES        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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

Facility Name & ID Number Winchester House

# 0010678 Report Period Beginning:

12/01/05 Ending:

11/30/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 189,077 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories Five

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

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

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

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

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

Adult Day Care

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>522,720</u>	<u>Prior to 1941</u>	<u>\$ 5,466</u>	1
2					2
3	<b>TOTALS</b>	<u>522,720</u>		<u>\$ 5,466</u>	3

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	360		1972	1971	\$ 5,306,095	\$		\$ 132,652	\$ 132,652	\$ 4,381,370	4
5			1960	1959	503,487					503,487	5
6				1971	(100,596)						6
7				1959	(9,545)						7
8											8
	<b>Improvement Type**</b>										
9	Various		1972		31,454		20	786	786	26,736	9
10	Various		1978		44,855		20	1,121	1,121	31,398	10
11	Various		1982		8,135		20	325	325	7,809	11
12	Various		1984		83,196		20	2,708	2,708	59,577	12
13	Various		1986		1,764,063		20	88,203	88,203	1,764,063	13
14	Various		1987		327,427		20	13,272	13,272	254,116	14
15	Various		1988		61,984		20	464	464	58,736	15
16	Various		1989		73,376					73,376	16
17	Various		1990		148,792		20	9,918	9,918	158,710	17
18	Various		1991		88,501		20	4,426	4,426	66,376	18
19	Various		1992		73,149		20	2,717	2,717	59,610	19
20	Various		1993		290,100		20	15,342	15,342	199,446	20
21	Various		1994		106,546		20	7,103	7,103	85,237	21
22	Various		1995		246,714		20	15,240	15,240	167,643	22
23	Various		1996		185,343		20	10,740	10,740	107,411	23
24	Various		1997		102,384		20	6,556	6,556	59,011	24
25	Various		1998		184,007		20	11,353	11,353	90,825	25
26	Various		1999		214,009		20	14,214	14,214	99,504	26
27	Various		2000		108,195		20	9,655	9,655	57,934	27
28	Various		2001		237,702		20	8,660	8,660	43,298	28
29	Various		2002		42,369		20	1,733	1,733	6,933	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.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05 Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 10,121,742	\$		\$ 357,188	\$ 357,188	\$ 8,362,606	70

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

Facility Name &amp; ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05 Ending:

11/30/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 10,121,742	\$		\$ 357,188	\$ 357,188	\$ 8,362,606	1
2	Arch Fee - Sidewalk Project	2003	640		20	32	32	128	2
3	Emergency Panel	2003	3,389		20	169	169	676	3
4	Controller Unit on Doors	2003	7,988		20	399	399	1,596	4
5	Roll Thru Refrigerator	2003	7,000		20	350	350	1,400	5
6	Credit on Door	2003	(2,000)		20	(100)	(100)	(400)	6
7	Water Softener System	2003	9,995		20	500	500	2,000	7
8	Room #2105 Renovation	2003	2,879		20	144	144	444	8
9	Room #2107 Renovation	2003	2,879		20	144	144	444	9
10	Room #3105 Renovation	2003	2,879		20	144	144	444	10
11	Room #3107 Renovation	2003	2,879		20	144	144	444	11
12	Room #4105 Renovation	2003	2,879		20	144	144	444	12
13	Room #4107 Renovation	2003	2,879		20	144	144	444	13
14	Room #5105 Renovation	2003	2,879		20	144	144	444	14
15	Room #5107 Renovation	2003	2,879		20	144	144	444	15
16	Elevator Valve	2003	2,700		20	135	135	518	16
17	Elevator Key Switch Circuit	2003	2,963		20	148	148	568	17
18	Engineer - HVAC	2003	4,780		20	239	239	737	18
19	Engineer - Roof Top Air Unit	2003	1,880		20	94	94	306	19
20	Grease Trap	2003	6,635		20	332	332	1,272	20
21	Electrician - Wiring	2003	960		20	48	48	148	21
22	Water Softener System	2003	9,995		20	500	500	1,666	22
23	Architect - Lighting	2003	5,680		20	284	284	899	23
24	Flooring	2003	840		20	42	42	137	24
25	Flooring	2003	501		20	25	25	94	25
26	Flooring	2003	738		20	37	37	141	26
27	Plumbing	2003	702		20	35	35	126	27
28	Service Sink	2003	722		20	36	36	141	28
29	Boiler Repair	2003	2,161		20	108	108	342	29
30	Built-in Closet Units	2003	15,021		20	751	751	2,879	30
31	Awning	2003	1,190		20	60	60	209	31
32	Door - Motor Gear Box	2003	790		20	40	40	139	32
33	Doors	2003	7,988		20	399	399	1,531	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,238,032	\$		\$ 363,003	\$ 363,003	\$ 8,383,411	34

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

Facility Name &amp; ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05 Ending:

11/30/06

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 10,238,032	\$		\$ 363,003	\$ 363,003	\$ 8,383,411	1
2	Doors	2003	1,693		20	85	85	325	2
3	Locks	2003	4,385		20	219	219	804	3
4	Carrier Air Handler	2003	173,602		20	8,680	8,680	26,764	4
5	Shelves	2004	9,773		20	489	489	1,100	5
6	Sidewalk Replacement	2004	37,295		20	1,865	1,865	4,351	6
7	Sidewalk Replacement	2004	12,475		20	624	624	1,404	7
8	Sidewalk Replacement	2004	12,350		20	618	618	1,338	8
9	Engineer - Rooftop Air Unit	2004	1,280		20	64	64	176	9
10	Staircase Railings	2004	5,770		20	289	289	746	10
11	Architect - Sidewalk Replacement	2004	9,630		20	482	482	1,084	11
12	Infrared Door Curtain Unit	2004	1,880		20	94	94	259	12
13	Elevator Repair	2004	517		10	52	52	151	13
14	Elevator Repair	2004	1,392		10	139	139	406	14
15	Elevator Repair	2004	522		10	52	52	152	15
16	Wall Bumpers	2005	406		20	20	20	40	16
17	Elevator Repair	2005	1,980		20	99	99	198	17
18	Door Latches	2005	11,256		20	563	563	1,126	18
19	Door Latches	2005	2,989		20	149	149	298	19
20	Doors	2005	3,935		20	197	197	394	20
21	Doors	2005	2,485		20	124	124	248	21
22	Door Latches	2005	2,989		20	149	149	298	22
23	Replace Fire Hydrant	2006	4,385		20	219	219	110	23
24	Cooling Tower Gear Box and Motor	2006	8,600		20	430	430	215	24
25	Cart Wash Room Epoxy	2006	6,228		20	311	311	156	25
26	Replace Cubicle Curtains	2006	51,326		20	2,566	2,566	1,283	26
27	Rehabilitation Room Renovation	2006	34,292		20	1,715	1,715	858	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,641,467	\$		\$ 383,297	\$ 383,297	\$ 8,427,695	34

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,937,816	\$	\$ 298,912	\$ 298,912	10	\$ 2,436,552	71
72	Current Year Purchases	81,152		8,115	8,115	10	8,115	72
73	Fully Depreciated Assets	35,327				10	35,327	73
74								74
75	TOTALS	\$ 3,054,295	\$	\$ 307,027	\$ 307,027		\$ 2,479,994	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	Resident Outings	1997 Chevy Van	1997	\$ 32,900	\$	\$ 1,775	\$ 1,775	5	\$ 21,860	76
77	Resident Outings	2002 Ford Bus	2002	96,757		9,676	9,676	5	38,773	77
78	Maintenance	2002 Chevy Truck	2002	30,709		6,142	6,142	5	24,576	78
79										79
80	TOTALS			\$ 160,366	\$	\$ 17,593	\$ 17,593		\$ 85,209	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,861,594	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 707,917	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 707,917	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,992,898	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	Building -1960	\$ 180,634	\$	\$ 180,634	86
87	Computer - Marketing - 2005	1,639		710	87
88	Computer - Marketing - 2005	5,484		2,376	88
89	Adult Day Care - 2005	110,141			89
90					90
91	TOTALS	\$ 297,898	\$	\$ 183,720	91

G. Construction-in-Progress

	Description	Cost	
92	Fire Supression System	\$ 1,502,852	92
93			93
94			94
95		\$ 1,502,852	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

\*\*

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

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 10,770

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. 2007 \$ \_\_\_\_\_

13. 2008 \$ \_\_\_\_\_

14. 2009 \$ \_\_\_\_\_

\* 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.

Supplemental Schedule of Movable Equipment Rental

	Description	Amount
16A	Copy Machines	9,133
16B	Fax Machines	905
16C	Postage Machine	732

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/05 Ending: 11/30/06

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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. CLASSROOM PORTION:</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 CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 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	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$		\$ 111,611	\$		\$ 111,611	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			21,822			21,822	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			121,196			121,196	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$ 254,629	\$		\$ 254,629	14

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

STATE OF ILLINOIS

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning: 12/01/05

Ending:

11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/06

(last day of reporting year)

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	\$ (1,103,364)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,699,052		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	198,412		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,794,100	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,794,100	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 208,623	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	770,160		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Deposits Payable</u>	200,820		36
37	<u>Public Aid IGT</u>	684,996		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,864,599	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,864,599	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 929,501	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,794,100	\$	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (303,498)	1
2	Restatements (describe):		2
3	Bad Debt Allowance Adjustment	660,018	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 356,520	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	572,981	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 572,981</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 929,501</b>	<b>24</b> *

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

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/01/05Ending: 11/30/06**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	\$ 14,154,768	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 14,154,768	3
<b>B. Ancillary Revenue</b>			
4	Day Care	12,300	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 12,300	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,390	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	26,145	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	13,605	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 51,140	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	12,903	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 12,903	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	6,453,893	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,453,893	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 20,685,004	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,764,925	31
32	Health Care	9,454,750	32
33	General Administration	6,610,307	33
<b>B. Capital Expense</b>			
34	Ownership	10,787	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	271,254	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 20,112,023	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	572,981	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 572,981	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Num Winchester House

Supplemental Schedule of Revenues

Description	Amount
28A Property Taxes	4,010,899
28B Transfers form Other Funds	2,418,705
28C TIF District Property Taxes	10,594
28D All Other Miscellaneous (Adjusted Off Page 5)	2,478
28E Vending Machine Commissions	7,615
28F Sale of Assets	3,602
Total	<u>6,453,893</u>

Facility Name & ID Number Winchester House

# 0010678

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	1,405	1,622	\$ 66,391	\$ 40.93	1
2	Assistant Director of Nursing	1,840	2,112	88,759	42.03	2
3	Registered Nurses	63,087	70,388	2,244,982	31.89	3
4	Licensed Practical Nurses	23,293	26,900	738,410	27.45	4
5	CNAs & Orderlies	227,644	262,210	3,771,858	14.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,291	14,812	356,382	24.06	8
9	Activity Director	1,756	2,056	57,894	28.16	9
10	Activity Assistants	28,043	32,651	381,533	11.69	10
11	Social Service Workers	5,216	6,108	148,065	24.24	11
12	Dietician	3,665	4,258	92,405	21.70	12
13	Food Service Supervisor	1,173	1,864	74,528	39.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	56,942	64,729	908,652	14.04	15
16	Dishwashers					16
17	Maintenance Workers	17,352	20,324	474,209	23.33	17
18	Housekeepers	28,028	33,007	478,550	14.50	18
19	Laundry	14,851	17,322	228,819	13.21	19
20	Administrator	1,748	2,000	114,416	57.21	20
21	Assistant Administrator	312	464	10,083	21.73	21
22	Other Administrative	7,207	8,618	231,633	26.88	22
23	Office Manager					23
24	Clerical	18,729	15,790	315,779	20.00	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	3,434	4,283	79,036	18.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>see supplemental</u>	21,809	4,283	471,491	110.08	33
34	TOTAL (lines 1 - 33)	539,825	595,801	\$ 11,333,875 *	\$ 19.02	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		\$		35
36	Medical Director	Monthly	18,966	09-03	36
37	Medical Records Consultant	69	4,091	10-03	37
38	Nurse Consultant	36	7,203	10-03	38
39	Pharmacist Consultant	Monthly	4,660	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	39	2,100	11-03	44
45	Social Service Consultant	44	2,508	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	188	\$ 39,528		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,454	\$ 362,427		50
51	Licensed Practical Nurses	279	11,234		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,733	\$ 373,661		53

B. CONSULTANT SERVICES

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Education	3,039	3,737	\$ 119,425	\$ 31.96	1
2	Central Supply	3,663	4,136	72,757	17.59	2
3	Nursing Secretarial	14,043	16,650	262,684	15.78	3
4	Adult Day Care (Adj P5)	752	752	8,994	11.96	4
5	Marketing (Adj P5)	312	312	7,631	24.46	5
		21,809	25,587	471,491		

Facility Name & ID Number Winchester House

Report Period Beginning: 12/01/05

Ending: 11/30/06

**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	
Steve Nussbaum	Administrator	0	\$ 38,491	Workers' Compensation Insurance	\$ 390,766	IDPH License Fee	\$ 1,990	
James Weibeler	Administrator	0	75,924	Unemployment Compensation Insurance	41,580	Advertising: Employee Recruitment		
Joan Bodenlos	Asst Admin	0	10,083	FICA Taxes	878,258	Health Care Worker Background Check	880	
				Employee Health Insurance	1,912,935	(Indicate # of checks performed <u>88</u> )		
				Employee Meals		Resident Background Checks	271 2,710	
				Illinois Municipal Retirement Fund (IMRF)*	1,129,250	Dues	20,778	
				Employee Relations	1,298	Licenses	80	
				Employee Physicals	10,318			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 124,498					
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
	\$					\$		
							Out-of-State Travel	\$ 365
							Wisconsin Seminar (allowable)	
							In-State Travel	
							Seminar Expense	4,210
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							TOTAL	
C. Professional Services								
Vendor/Payee	Type	Amount						
FR&R	Consulting	\$ 33,922						
MPA	Consulting	53,295						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 87,217					

\* Attach copy of IMRF notifications

\*\*See instructions.



**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. LSN - 14,529 & Cnty Nrsg Home Assn \$2,840
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 101,998 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 197,100  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,390
- (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. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? Yes
- 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Virchow, Krause & Company, 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. Not Complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number      Wabesate House      # 0010678      Travel and Seminar Expense FY2006

Name	Title	Date	Amount	Description	State		
<b>Non Nursing</b>							
B King	Dietician	1/19/2006	\$45.00	Continuing Ed to maintain Dietitian Registration	Illinois		
J Miller	Dietician	1/19/2006	\$45.00	Continuing Ed to maintain Dietitian Registration	Illinois		
M Fields	F Coordinator	1/9/2006	\$99.00	Medicare New Year's Resolutions	Illinois		
J Keyes	Human R	4/27/2006	\$20.00	Criminal Background Symposium	Illinois		
B King	Dietician	4/26/2006	\$110.52	LSN	Illinois		
J Fields	Medical Records	4/26/2006	\$110.52	LSN	Illinois		
J Demman	U Secretary	4/26/2006	\$110.52	LSN	Illinois		
D Benetti	Activities	4/26/2006	\$110.52	LSN	Illinois		
M Punnett	Volunteer Co-or	4/26/2006	\$110.52	LSN	Illinois		
P McDonald	Social Worker	4/26/2006	\$110.52	LSN	Illinois		
T Hodge	Social Worker	4/26/2006	\$110.52	LSN	Illinois		
C Acosta	Dietician	4/26/2006	\$110.52	LSN	Illinois		
O Navarez	Human R	4/26/2006	\$110.52	LSN	Illinois		
J Keyes	Human R	5/23/2006	\$145.00	OBRA Survey	Illinois		
D Benetti	Activities	5/11/2006	\$145.00	New Psychiatric MDS Section S	Illinois		
O Navarez	Dietician	7/16/2006	\$105.00	Dietary Managers Assoc	Illinois		
J Miller	Dietician	7/16/2006	\$150.00	Dietary Managers Assoc	Illinois		
F Lila	Asst Admin	7/16/2006	\$107.50	A Tale of Transformation	Illinois		
M Punnett	Volunteer Co-or	7/21/2006	\$29.95	Alzheimer's Awareness	Illinois		
M Punnett	Volunteer Co-or	7/27/2006	\$29.95	Assessment Evaluation & Facility Population Are You Ready for the New	Illinois		
M Punnett	Volunteer Co-or	8/3/2006	\$79.95	Guidelines	Illinois		
M Punnett	Volunteer Co-or	8/18/2006	\$29.90	Attitudes, Choices & Diversity	Illinois		
J Weibeler	Administrator	10/13/2006	\$685.00	AAHSA Conference	California	2	\$685.00
J Fields	Clerk	11/29/2006	\$31.00	Overview of Medicare A & B	Wisconsin	1	
M Fields	F Coordinator	11/29/2006	\$31.00	Overview of Medicare A & B	Wisconsin	1	
J Bacci	Food Service	11/15/2006	\$105.00	Sen-Safe Certificate	Wisconsin	1	
B King	Food Service	10/11/2006	\$85.00	Continuing Ed to maintain Dietitian Registration	Illinois		
C Acosta	Food Service	10/11/2006	\$85.00	Continuing Ed to maintain Dietitian Registration	Illinois		
J Weibeler	Administrator	11/4/2006	\$1,618.49	AAHSA Conference	California	2	\$1,618.49
<b>Total</b>			<b>\$4,921.84</b>				
<b>Nursing</b>							
B Cochran	RN	3/01/06	\$125.00	Writing Resident Care Plans	Illinois		
M Cua	RN	3/1/2006	\$125.00	Writing Resident Care Plans	Illinois		
Nursing group	Nursing	12/5/2005	\$197.37	Negativity in the work place	Illinois		
Nursing group	Nursing	12/5/2005	\$84.43	21 Ways to defuse anger	Illinois		
K Walker	DON	2/14/2006	\$99.00	Documentation	Illinois		
K Walker	DON	2/28/2006	\$95.00	Medicaid Reimbursement	Illinois		
E Escalante	RN	2/28/2006	\$95.00	Medicaid Reimbursement	Illinois		
C Brown	RN	2/28/2006	\$95.00	Medicaid Reimbursement	Illinois		
D Pecora	RN	2/28/2006	\$95.00	Medicaid Reimbursement	Illinois		
E Cababag	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
C Fernandez	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
E Maggarity	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
S Niro	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
R Johnson	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
M Gibbons	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
B Janowitz	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
A Benny	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
U Sierzputowska	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
R Blanda	LPN	4/26/2006	\$110.52	LSN Conference	Illinois		
R Stec	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
E Correa	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
V Anderson	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
M Vuong	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
P Cabe	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
J deAlfosa	CAN	4/26/2006	\$110.52	LSN Conference	Illinois		
S Kinkaid	LPN	4/26/2006	\$110.52	LSN Conference	Illinois		
C Brown	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
E Escalante	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
M Cua	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
B Cochran	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
E Wright	LPN	4/26/2006	\$110.52	LSN Conference	Illinois		
E Urabanzo	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
K Walker	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
V Eason	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
P Wright	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
T Mejos	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
L Butler	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
D Pecora	RN	4/26/2006	\$110.52	LSN Conference	Illinois		
K Walker	RN	5/5/2006	\$250.00	Learn, Empower, Achieve	Illinois		
E Escalante	RN	5/5/2006	\$145.00	New Psychiatric MDS Section S	Illinois		
C Brown	RN	5/5/2006	\$145.00	New Psychiatric MDS Section S	Illinois		
K Walker	RN	5/23/2006	\$145.00	Survey	Illinois		
K Walker	RN	7/17/2006	\$107.50	A Tale of Transformation	Illinois		
N Dunn	RN	7/17/2006	\$107.50	A Tale of Transformation	Illinois		
R Hewkin	RN	7/17/2006	\$107.50	A Tale of Transformation	Illinois		
M Perkins	RN	7/17/2006	\$107.50	A Tale of Transformation	Illinois		
M Ajimoren	RN	7/17/2006	\$107.50	A Tale of Transformation	Illinois		
E Escalante	RN	8/9/2006	\$99.00	Dealing with Difficult People	Wisconsin	1	
B Cochran	RN	8/9/2006	\$99.00	Dealing with Difficult People	Wisconsin	1	
D Pecora	RN	8/9/2006	\$357.25	MDS/PPS Seminar	Illinois		
L Butler	RN	8/14/2006	\$357.25	MDS/PPS Seminar	Illinois		
C Brown	RN	10/4/2006	\$169.00	Challenging Geriatric Behaviors	Illinois		
B Cochran	RN	10/4/2006	\$169.00	Challenging Geriatric Behaviors	Illinois		
M Cua	RN	10/4/2006	\$169.00	Challenging Geriatric Behaviors	Illinois		
D Pecora	RN	10/18/2006	\$169.00	Certificate in Gerontology	Illinois		
<b>Total</b>			<b>\$6,878.82</b>				<b>\$2,303.49</b>