

Facility Name & ID Number Winchester House

0010678 Report Period Beginning: 12/01/07 Ending: 11/30/08

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 _____

	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	360	Skilled (SNF)	360	131,760	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	360	TOTALS	360	131,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	9,940	1,089	9,663	20,692	8
9	SNF/PED					9
10	ICF	50,829	11,402		62,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,769	12,491	9,663	82,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.93%

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

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 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 number of beds certified 360 and days of care provided 9,663

Medicare Intermediary Wisconsin Physicians Service/Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2008 Fiscal Year: 11/30/2008

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/07 Ending: 11/30/08

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	1,015,687	68,248		1,083,935		1,083,935		1,083,935		1
2	Food Purchase		534,059		534,059		534,059	(11,322)	522,737		2
3	Housekeeping	499,160	46,882	5,446	551,488		551,488		551,488		3
4	Laundry	236,325	16,186	19,012	271,523		271,523	(16,613)	254,910		4
5	Heat and Other Utilities			626,716	626,716		626,716		626,716		5
6	Maintenance	465,911	102,226	120,356	688,493		688,493	(33,976)	654,517		6
7	Other (specify):*										7
8	TOTAL General Services	2,217,083	767,601	771,530	3,756,214		3,756,214	(61,911)	3,694,303		8
	B. Health Care and Programs										
9	Medical Director			19,677	19,677		19,677		19,677		9
10	Nursing and Medical Records	7,167,940	663,005	320,407	8,151,352		8,151,352		8,151,352		10
10a	Therapy	235,039	339	2,681	238,059		238,059		238,059		10a
11	Activities	436,042	10,047	2,876	448,965		448,965		448,965		11
12	Social Services	145,558			145,558		145,558		145,558		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,984,579	673,391	345,641	9,003,611		9,003,611		9,003,611		16
	C. General Administration										
17	Administrative	120,565			120,565		120,565		120,565		17
18	Directors Fees										18
19	Professional Services							91,249	91,249		19
20	Dues, Fees, Subscriptions & Promotions			39,282	39,282		39,282	(16,353)	22,929		20
21	Clerical & General Office Expenses	567,820	34,105	678,535	1,280,460		1,280,460	(53,814)	1,226,646		21
22	Employee Benefits & Payroll Taxes			3,587,555	3,587,555		3,587,555	366,253	3,953,808		22
23	Inservice Training & Education			2,413	2,413		2,413		2,413		23
24	Travel and Seminar			8,106	8,106		8,106		8,106		24
25	Other Admin. Staff Transportation			3,119	3,119		3,119		3,119		25
26	Insurance-Prop.Liab.Malpractice							372,618	372,618		26
27	Other (specify):* Intergovernmental Transfer			3,992,894	3,992,894		3,992,894		3,992,894		27
28	TOTAL General Administration	688,385	34,105	8,311,904	9,034,394		9,034,394	759,953	9,794,347		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,890,047	1,475,097	9,429,075	21,794,219		21,794,219	698,042	22,492,261		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

Winchester House

#0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							620,850	620,850			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			6,993	6,993		6,993		6,993			35
36	Other (specify):*											36
37	TOTAL Ownership			6,993	6,993		6,993	620,850	627,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			783,632	783,632		783,632		783,632			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,586	197,586		197,586		197,586			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			981,218	981,218		981,218		981,218			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,890,047	1,475,097	10,417,286	22,782,430		22,782,430	1,318,892	24,101,322			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,322)	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	(16,613)	04		8
9	Non-Straightline Depreciation	620,850	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	(7,765)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,588)	20		28
29	Other-Attach Schedule <u>See Attached</u>	(2,696,571)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,120,009)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	2,509,536	22	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,509,536		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 389,527		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Winchester House

ID# 0010678
 Report Period Beginning: 12/01/07
 Ending: 11/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized Repairs and Maintenance	\$ (2,634,374)	06	1
2	To Capitalize Current Year Asset Additions	(8,383)	06	2
3	Marketing Wage	(53,111)	21	3
4	Misc. Income	(703)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,696,571)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,322)	0	0	0	0	0	0	0	0	0	0	(11,322)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(16,613)	0	0	0	0	0	0	0	0	0	0	(16,613)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,642,757)	168,224	2,440,557	0	0	0	0	0	0	0	0	(33,976)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,670,692)	168,224	2,440,557	0	(61,911)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	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	22,270	68,979	0	0	0	0	0	0	0	0	91,249	19
20	Fees, Subscriptions & Promotions	(16,353)	0	0	0	0	0	0	0	0	0	0	(16,353)	20
21	Clerical & General Office Expenses	(53,814)	0	0	0	0	0	0	0	0	0	0	(53,814)	21
22	Employee Benefits & Payroll Taxes		366,253	0	0	0	0	0	0	0	0	0	366,253	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	372,618	0	0	0	0	0	0	0	0	0	372,618	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(70,167)	761,141	68,979	0	759,953	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,740,859)	929,365	2,509,536	0	698,042	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	620,850	0	0	0	0	0	0	0	0	0	0	620,850	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	TOTAL Ownership	620,850	0	0	0	0	0	0	0	0	0	0	620,850	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,120,009)	929,365	2,509,536	0	0	0	0	0	0	0	0	1,318,892	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
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%	\$ 30,645	\$ 30,645	1
2	V	22	Worker's Compensation	County of Lake	100.00%	329,968	329,968	2
3	V	26	Liability, Prop & Malpractice Insurance	County of Lake	100.00%	372,618	372,618	3
4	V	22	Employee Physicals	County of Lake	100.00%	3,240	3,240	4
5	V	22	Employee Relations	County of Lake	100.00%	2,400	2,400	5
6	V	22	FICA	County of Lake	100.00%	819,049		6
7	V	22	IMRF	County of Lake	100.00%	951,089		7
8	V	21	Indirect A&G Cost Allocation	County of Lake	100.00%	642,538		8
9	V	22	Health-Life-Dental Insurance	County of Lake	100.00%	1,817,416		9
10	V	19	Legal Fees	County of Lake	100.00%	22,270	22,270	10
11	V	6	Rooftop Unit Repairs	County of Lake	100.00%	86,710	86,710	11
12	V	6	Generator Repair	County of Lake	100.00%	6,319	6,319	12
13	V	6	Dish Machine Replacement	County of Lake	100.00%	75,195	75,195	13
14	Total		\$ 4,230,092			\$ 5,159,457	\$ *	929,365 14

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

Facility Name & ID Number Winchester House

0010678

Report Period Beginning: 12/01/07

Ending: 11/30/08

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)		
15	V	6	Entryway Concrete Repair	\$	County of Lake	100.00%	\$ 20,067	\$ 20,067	15
16	V	6	Annuciator Panels		County of Lake	100.00%	18,550	18,550	16
17	V	6	Fire Suppresion System		County of Lake	100.00%	2,293,006	2,293,006	17
18	V	6	Mold Remediation		County of Lake	100.00%	108,934	108,934	18
19	V	19	Facility Replacement Consultant		County of Lake	100.00%	68,979	68,979	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 2,509,536	\$ * 2,509,536	39

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/07 Ending: 11/30/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											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: 12/01/07 Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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:

12/01/07

Ending:

11/30/08

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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 2008 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number Winchester House

0010678 Report Period Beginning:

12/01/07 Ending:

11/30/08

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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>522,720</u>	<u>Prior to 1941</u>	<u>\$ 5,466</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	522,720		\$ 5,466	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 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	\$ 4,646,674	4
5		1960	1959	503,487					503,487	5
6			1971	(100,596)						6
7			1959	(9,545)						7
8										8
Improvement Type**										
9	Various		1972	31,454		20	786	786	28,308	9
10	Various		1978	44,855		20	1,121	1,121	33,640	10
11	Various		1982	8,135		20			8,135	11
12	Various		1984	83,196		20	2,708	2,708	64,993	12
13	Various		1986	1,764,063		20			1,764,063	13
14	Various		1987	327,427		20	13,272	13,272	280,660	14
15	Various		1988	61,984		20	464	464	59,664	15
16	Various		1989	73,376		20			73,376	16
17	Various		1990	148,792		20			148,792	17
18	Various		1991	88,501		20	4,426	4,426	75,228	18
19	Various		1992	73,149		20	2,717	2,717	65,044	19
20	Various		1993	290,100		20	15,342	15,342	230,130	20
21	Various		1994	106,546		20	7,103	7,103	99,443	21
22	Various		1995	246,714		20	15,240	15,240	198,123	22
23	Various		1996	185,343		20	10,740	10,740	128,891	23
24	Various		1997	102,384		20	6,556	6,556	72,123	24
25	Various		1998	184,007		20	11,353	11,353	113,531	25
26	Various		1999	214,009		20	14,214	14,214	127,932	26
27	Various		2000	108,195		20	9,655	9,655	77,244	27
28	Various		2001	237,702		20	8,660	8,660	60,618	28
29	Various		2002	42,369		20	1,733	1,733	10,399	29
30	Various		2003	295,970		20	14,799	14,799	78,386	30
31	Various		2004	90,453		20	4,525	4,525	19,508	31
32	Various		2004	2,431		10	243	243	1,195	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Winchester House

0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	
37	Wall Bumpers	2005	\$ 406	\$	20	\$ 20	\$ 20	\$ 80	37
38	Elevator Repair	2005	1,980		20	99	99	396	38
39	Door Latches	2005	11,256		20	563	563	2,252	39
40	Door Latches	2005	2,989		20	149	149	596	40
41	Doors	2005	3,935		20	197	197	788	41
42	Doors	2005	2,485		20	124	124	496	42
43	Door Latches	2005	2,989		20	149	149	596	43
44	Replace Fire Hydrant	2006	4,385		20	219	219	548	44
45	Cooling Tower Gear Box and Motor	2006	8,600		20	430	430	1,075	45
46	Cart Wash Room Epoxy	2006	6,228		20	311	311	778	46
47	Replace Cubicle Curtains	2006	51,326		20	2,566	2,566	6,415	47
48	Rehabilitation Room Renovation	2006	34,292		20	1,715	1,715	4,288	48
49	Garbage Disposal	2007	3,375		20	169	169	239	49
50	Hydrant Repair	2007	5,983		20	299	299	498	50
51	Chiller Repairs	2007	2,845		20	142	142	201	51
52	Boiler Repair	2007	6,651		20	333	333	666	52
53	Ice-Water Dispenser	2007	2,762		20	138	138	150	53
54	Wardrobe Curtains	2007	2,642		20	132	132	209	54
55	Floor Scrubber	2007	6,980		20	349	349	396	55
56	Elevator Repairs	2007	7,157		20	358	358	649	56
57	Water Damage Repair	2007	60,887		20	3,044	3,044	5,574	57
58	Mold Remediation	2008	108,934		20	5,447	5,447	2,669	58
59	Chairs	2008	11,508		20	575	575	48	59
60	Ice makers	2008	11,358		20	568	568	199	60
61	Beauty Salon Countertops	2008	2,727		20	136	136	11	61
62	Rooftop Unit Repairs	2008	86,710		20	4,336	4,336	361	62
63	Generator Repair	2008	6,319		20	316	316	158	63
64	Dish Machine Replacement	2008	75,195		20	3,760	3,760	1,567	64
65	Entryway Concrete Repair	2008	20,067		20	1,003	1,003	251	65
66	Annunciator Panels	2008	18,550		20	928	928	696	66
67	Fire Suppression System	2008	2,293,006		20	114,650	114,650	114,650	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,375,123	\$		\$ 421,534	\$ 421,534	\$ 9,117,087	70

**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:

12/01/07

Ending:

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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	\$ 1,870,054	\$	\$ 187,027	\$ 187,027	10	\$ 1,588,597	71
72	Current Year Purchases	8,383		838	838	10	70	72
73	Fully Depreciated Assets	1,238,844				10	1,547,447	73
74								74
75	TOTALS	\$ 3,117,281	\$	\$ 187,865	\$ 187,865		\$ 3,136,114	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	\$ 25,410	76
77	Resident Outings	2002 Ford Bus	2002	96,757		9,676	9,676	5	58,125	77
78	Maintenance	2002 Chevy Truck	2002	30,709				5	30,709	78
79										79
80	TOTALS			\$ 160,366	\$	\$ 11,451	\$ 11,451		\$ 114,244	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)	\$ 16,658,236	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)	\$ 620,850	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 620,850	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,367,445	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					87
88					88
89					89
90					90
91	TOTALS	\$ 180,634	\$	\$ 180,634	91

G. Construction-in-Progress

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

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

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

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	TOTAL				\$ _____			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? _____

16. Rental Amount for movable equipment: \$ 6,993 Description: See Attached Schedule YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

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. <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 CNA _____</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 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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$		\$ 302,418	\$		\$ 302,418	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			116,271			116,271	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			364,943			364,943	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	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 783,632	\$		\$ 783,632	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.

Facility Name & ID Number Winchester House

0010678

Report Period Beginning: 12/01/07

Ending: 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/08

(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	\$ 6,632,784	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,555,281		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):	777,594		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,965,659	\$	10
B. Long-Term Assets				
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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,965,659	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 311,768	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,306,517		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
Other Current Liabilities(specify):				
36	<u>Deposits Payable</u>	207,828		36
37	<u>Public Aid IGT</u>	241,167		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,067,280	\$	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
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,067,280	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,103,015	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,170,295	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,236,052	1
2	Restatements (describe):		2
3	Due From Other Funds Adjustment	4,444	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,240,496	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,862,519	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,862,519	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)	\$ 9,103,015	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/01/07Ending: 11/30/08**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,041,103	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,041,103	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 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	11,322	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	16,613	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,935	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	228,421	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 228,421	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,347,490	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,347,490	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,644,949	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,756,214	31
32	Health Care	9,003,611	32
33	General Administration	9,034,394	33
B. Capital Expense			
34	Ownership	6,993	34
C. Ancillary Expense			
35	Special Cost Centers	783,632	35
36	Provider Participation Fee	197,586	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,782,430	40
41	Income before Income Taxes (line 30 minus line 40)**	3,862,519	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,862,519	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 Winchester House

0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	1,912	2,072	\$ 99,563	\$ 48.05	1
2	Assistant Director of Nursing	1,636	2,048	79,244	38.69	2
3	Registered Nurses	55,223	62,871	2,111,244	33.58	3
4	Licensed Practical Nurses	16,853	19,316	591,898	30.64	4
5	CNAs & Orderlies	202,975	232,410	3,718,471	16.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,979	13,103	235,039	17.94	8
9	Activity Director	1,700	2,104	65,176	30.98	9
10	Activity Assistants	24,966	21,481	308,502	14.36	10
11	Social Service Workers	5,514	6,305	153,657	24.37	11
12	Dietician	3,620	4,271	106,877	25.02	12
13	Food Service Supervisor	1,641	2,080	85,776	41.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	45,388	52,709	852,949	16.18	15
16	Dishwashers					16
17	Maintenance Workers	14,813	17,025	462,787	27.18	17
18	Housekeepers	27,901	36,615	546,791	14.93	18
19	Laundry	10,320	12,063	202,238	16.77	19
20	Administrator	1,900	2,080	120,565	57.96	20
21	Assistant Administrator					21
22	Other Administrative	23,177	26,596	603,579	22.69	22
23	Office Manager					23
24	Clerical	5,672	6,530	120,956	18.52	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	3,629	4,269	85,738	20.08	31
32	Other Health Care(specify)					32
33	Other(specify)	15,113	17,556	338,997	19.31	33
34	TOTAL (lines 1 - 33)	474,932	543,504	\$ 10,890,047 *	\$ 20.04	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	19,677	09-03	36
37	Medical Records Consultant	85	5,043	10-03	37
38	Nurse Consultant	198	15,484	10-03	38
39	Pharmacist Consultant	Monthly	9,534	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	41	2,681	11-03	44
45	Social Service Consultant	44	2,876	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	368	\$ 55,295		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,500	\$ 168,869	10-03	50
51	Licensed Practical Nurses	1,745	77,545	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,245	\$ 246,414		53

Facility Name & ID Number Winchester House

Report Period Beginning: 12/01/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description	Amount	Description	Amount		Amount
Anne Wagner	Administrator	0	\$ 120,565	Workers' Compensation Insurance	\$ 329,968	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	30,645	Advertising: Employee Recruitment			
				FICA Taxes	819,049	Health Care Worker Background Check	2,000		
				Employee Health Insurance	1,817,417	(Indicate # of checks performed 24)			
				Employee Meals		Patient Background Checks	171	2,000	
				Illinois Municipal Retirement Fund (IMRF)*	951,089	Dues		16,939	
				Employee Relations	2,400				
				Employee Physicals	3,240				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,565	TOTAL (agree to Schedule V, line 22, col.8)		\$ 3,953,808	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 22,929
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	\$ 0	
							In-State Travel	1,887	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	6,219	
C. Professional Services									
Vendor/Payee	Type	Amount							
Swanson, Martin & Bell, LLP	Legal Fees	\$ 14,482							
Wysocki and Smith	Legal Fees	7,788							
Mngmt Performance Assoc	Consultant	68,979							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 91,249	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 8,106	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/01/07Ending: 11/30/08**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 - \$14,479 & County Nursing Home Assn - \$2,460
- (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. \$ 89,533 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. \$ 197,586
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. \$ 11,322
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule of Other Admin. Staff Transportation

Auto Expense: Winchester House (mileage Reimbursement)	\$3,119
Auto Expense: Related Parties - See Page 6	0
Auto Expense: Page 5 and 5A Adjustments	0
Auto Expense: Total	<u>\$3,119</u>

Facility Name & ID Number

Winchester House

#

0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

County of Lake Board Members

Angelo Kyle

Ann Maine

Anne Bassi

Audrey Nixon

Bonnie Carter

Brent Paxton

Carol Calabresa

David Stolman

Diana O'Kelly

Diane Hewitt

Linda Pedersen

Mary Cunningham

Melinda Bush

Michael Talbett

Michelle Feldman

Pamela Newton

Pat Carey

Robert Sabonjian

Steve Carlson

Stevenson Mountsier

Susan Gravenhorst

Suzi Schmidt

Terry Wilke

Supplemental Schedule of Movable Equipment Rental

	<u>Description</u>	<u>Amount</u>
16A	Copy Machines	5,313
16B	Fax Machines	1,160
16C	Postage Machine	520
		<u>6,993</u>

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/08**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Other Current Assets			
09A	Interest Receivable	\$ 2,952	\$	
09B	Taxes Receivable	3,720,563		
09C	Deferred Revenue	0		
09D	Deferred Property Tax	0		
09E	Due From Other Funds	152,567		
		<u>3,876,082</u>	<u></u>	
	B. Other Long-Term Assets			
23A				
23B				
23C				
		<u></u>	<u></u>	

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
36A		\$	\$	
36B				
36C				
		<u></u>	<u></u>	
	D. Long-Term Liabilities			
43A				
43B				
43C				
		<u></u>	<u></u>	

Facility Name & ID Num Winchester House

0010678

Report Period Beginning 12/01/07

Ending:

11/30/08

Supplemental Schedule of Revenues

Description	Amount
28A Property Taxes	5,564,200
28B Transfers form Other Funds	1,769,962
28C TIF District Property Taxes	4,684
28D All Other Miscellaneous (Adjusted Off Page 5)	1,815
28E Vending Machine Commissions	6,445
28F Proceeds of Tax Sales	384
Total	<u>7,347,490</u>

Facility Name & ID Number

Winchester House

#

0010678

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	
2	Central Supply	3,718	4,303	84,402	19.61	2
3	Nursing Secretarial	9,307	11,081	201,484	18.18	3
4	Marketing (Adj P5)	2,088	2,172	53,111	24.45	5
		15,113	17,556	338,997		

Trips & Training 2007/2008

Non Nursing

Name	Dept	Date	Cost	Description of semi	State
A Gardner	Food	1/8/08	58.00	Food & Sanitation	Illinois
C Acosta	Food	1/8/08	58.00	Food & Sanitation	Illinois
O Navares	Food	1/8/08	58.00	Food & Sanitation	Illinois
	Food Service	2/28/08	55.00	Food & Sanitation	Illinois
M Wall	HR	3/18/08	199.00	FMLA Compliance	Illinois
N Opulencia	Admin	2/28/08	68.00	Billing & Complianc	Illinois
B Fields	Admin	2/28/08	68.00	Billing & Complianc	Illinois
J Fields	Admin	2/28/08	68.00	Billing & Complianc	Illinois
M Wall	Human Resources		299.00	EEO Training	Illinois
P Rose	Admin	4/2/08	186.34	LSN Conference	Illinois
J Woodfield	Social Services	4/2/08	186.34	LSN Conference	Illinois
P McDonald	Social Services	4/2/08	186.34	LSN Conference	Illinois
D Benetti	Social Services	4/2/08	186.34	LSN Conference	Illinois
M Wall	Human Resources	4/2/08	186.34	LSN Conference	Illinois
B Duncan	Activities	4/2/08	186.34	LSN Conference	Illinois
A Henningsen	Activities	4/2/08	186.34	LSN Conference	Illinois
B King	Food Service	4/2/08	186.34	LSN Conference	Illinois
Olivia Navares	Food Service	4/2/08	186.34	LSN Conference	Illinois
Joyce Miller	Food Service	4/2/08	186.34	LSN Conference	Illinois
O Navares	Food Service	5/7/08	30.00	U of I	Illinois
M Fields	Admin	6/8/08	52.50	Medicare	Illinois
Q Wysokinski	Admissions	6/8/08	52.50	Medicare	Illinois
J Miller	Food Service	5/20/08	70.00	Restaurant Show	Illinois
N DeDuzman	Food Service	5/20/08	70.00	Restaurant Show	Illinois
B Massey	Maintenance	5/28/08	70.00	Restaurant Show	Illinois
M Wall	Human Resources	6/2/09	1,295.00	SHRM Conference	Illinois
M Wall	Human Resources	6/19/08	160.00	Dues fro SHRM	
J Woodfield	Social Services	6/23/09	99.00	Enhancing Your Me	Illinois
J Miller	Food Service	7/15/08	329.00	Dietic Conference	Illinois
B King	Food Service	7/15/08	329.00	Dietic Conference	Illinois
J Meyer	Outreach	8/12/08	179.00	Rehab & Therapy f	Illinois
Q Wysokinski	Admissions	8/12/08	179.00	Rehab & Therapy f	Illinois

Trips & Training 2007/2008

J Meyer	Outreach	9/18/08	295.00	Senior Living Conf	Illinois
G Caranza	Food Service	11/9/08	55.00	Refresh sanitation	Illinois
			6,059.40		

Nursing

E Escalante	Nursing	4/2/08	186.24	LSN Conference	Illinois
C Brown	Nursing	4/2/08	186.34	LSN Conference	Illinois
M Cua	Nursing	4/2/08	186.34	LSN Conference	Illinois
D Pecora	Nursing	4/2/08	186.34	LSN Conference	Illinois
S DeAngelis	Nursing	4/2/08	186.34	LSN Conference	Illinois
Ray Amidei	Nursing	4/8/08	2,163.00	CPR Training	Illinois
Audio	Nursing	6/20/08	109.00	Analyzing Root Ca	Illinois
E Escalante	Nursing	6/23/09	99.00	Enhancing Your Me	Illinois
E Urbanzo	Nursing	8/16/08	129.00	Accident Preventio	Illinois
E Kochopolus	Nursing	8/16/08	129.00	Accident Preventio	Illinois
Manual	Nursing	8/16/08	170.56	Accident Preventio	Illinois
A Wagner	Nursing	10/8/09	250.25	DVD's nursing	Illinois
A Wagner	Nursing	10/17/08	379.66	Resident Center C	Illinois
A Wagner	Nursing	11/17/08	99.00	MDS 3.0 intro semi	Illinois
			4,460.07		