

Facility Name & ID Number Winchester House

0010678 Report Period Beginning: 12/01/08 Ending: 11/30/2009

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	131,400	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	131,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,621	904	9,522	21,047	8	
9	SNF/PED					9	
10	ICF	46,249	9,734		55,983	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	56,870	10,638	9,522	77,030	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.62%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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 9,522

Medicare Intermediary Wisconsin Physicians Service/Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2009 Fiscal Year: 11/30/2009

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/08 Ending: 11/30/2009

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	1,091,576	74,214		1,165,790		1,165,790		1,165,790		1
2	Food Purchase		494,452		494,452		494,452	(6,748)	487,704		2
3	Housekeeping	506,645	46,097	6,395	559,137		559,137		559,137		3
4	Laundry	222,378	3,136	276,208	501,722		501,722	(12,492)	489,230		4
5	Heat and Other Utilities			514,373	514,373		514,373		514,373		5
6	Maintenance	492,773	91,205	89,967	673,945		673,945	(398,561)	275,384		6
7	Other (specify):*										7
8	TOTAL General Services	2,313,372	709,104	886,943	3,909,419		3,909,419	(417,801)	3,491,618		8
	B. Health Care and Programs										
9	Medical Director			19,677	19,677		19,677		19,677		9
10	Nursing and Medical Records	7,212,114	848,691	447,497	8,508,302		8,508,302	225,797	8,734,099		10
10a	Therapy										10a
11	Activities	424,362	14,820	2,948	442,130		442,130		442,130		11
12	Social Services	130,787		2,948	133,735		133,735		133,735		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,767,263	863,511	473,070	9,103,844		9,103,844	225,797	9,329,641		16
	C. General Administration										
17	Administrative	119,308			119,308		119,308		119,308		17
18	Directors Fees										18
19	Professional Services							540,965	540,965		19
20	Dues, Fees, Subscriptions & Promotions			17,979	17,979		17,979	(7,795)	10,184		20
21	Clerical & General Office Expenses	642,569	31,058	722,694	1,396,321		1,396,321	(54,796)	1,341,525		21
22	Employee Benefits & Payroll Taxes			3,651,377	3,651,377		3,651,377	427,709	4,079,086		22
23	Inservice Training & Education			8,329	8,329		8,329		8,329		23
24	Travel and Seminar			12,034	12,034		12,034		12,034		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							341,524	341,524		26
27	Other (specify):*										27
28	TOTAL General Administration	761,877	31,058	4,412,413	5,205,348		5,205,348	1,247,607	6,452,955		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,842,512	1,603,673	5,772,426	18,218,611		18,218,611	1,055,603	19,274,214		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:

12/01/08

Ending:

11/30/2009

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							650,392	650,392			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			11,501	11,501		11,501		11,501			35
36	Other (specify):*											36
37	TOTAL Ownership			11,501	11,501		11,501	650,392	661,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			650,889	650,889		650,889		650,889			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,100	197,100		197,100		197,100			42
43	Other (specify):* Intergovernmental Transfer			3,406,114	3,406,114		3,406,114		3,406,114			43
44	TOTAL Special Cost Centers			4,254,103	4,254,103		4,254,103		4,254,103			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,842,512	1,603,673	10,038,030	22,484,215		22,484,215	1,705,995	24,190,210			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	(6,748)	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	(12,492)	04		8
9	Non-Straightline Depreciation	650,392	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	(2,340)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,455)	20		28
29	Other-Attach Schedule See Attached	(464,517)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 158,840		\$	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)	1,834,522	22	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,834,522		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,993,362		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

BHF USE ONLY							
48		49		50		51	52

Winchester House

ID# 0010678

Report Period Beginning: 12/01/08

Ending: 11/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized Repairs and Maintenance	\$ (325,973)	6	1
2	To Capitalize Current Year Asset Additions	(371,115)	6	2
3	Marketing Wage	(54,796)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(751,884)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/08

Ending:

11/30/2009

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	(6,748)	0	0	0	0	0	0	0	0	0	0	(6,748)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,492)	0	0	0	0	0	0	0	0	0	0	(12,492)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(697,088)	11,160	287,367	0	0	0	0	0	0	0	0	(398,561)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(716,328)	11,160	287,367	0	(417,801)	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	225,797	0	0	0	0	0	0	0	0	225,797	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	225,797	0	225,797	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	540,965	0	0	0	0	0	0	0	0	0	540,965	19
20	Fees, Subscriptions & Promotions	(7,795)	0	0	0	0	0	0	0	0	0	0	(7,795)	20
21	Clerical & General Office Expenses	(54,796)	0	0	0	0	0	0	0	0	0	0	(54,796)	21
22	Employee Benefits & Payroll Taxes		427,709	0	0	0	0	0	0	0	0	0	427,709	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	0	341,524	0	0	0	0	0	0	0	0	341,524	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(62,591)	968,674	341,524	0	1,247,607	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(778,919)	979,834	854,688	0	1,055,603	29							

STATE OF ILLINOIS

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/08

Ending:

Summary B

11/30/2009

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	650,392	0	0	0	0	0	0	0	0	0	0	650,392	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	650,392	0	0	0	0	0	0	0	0	0	0	650,392	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)	(128,527)	979,834	854,688	0	0	0	0	0	0	0	0	1,705,995	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
See attached list of County 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 Health Life and Dental Insurance	\$ 1,927,872	County of Lake	100.00%	\$ 1,927,872		1
2	V	22 FICA	813,261	County of Lake	100.00%	813,261		2
3	V	22 IMRF	898,741	County of Lake	100.00%	898,741		3
4	V	22 Unemployment Compensation		County of Lake	100.00%	30,105	30,105	4
5	V	22 Worker's Compensation		County of Lake	100.00%	387,078	387,078	5
6	V	22 Employee Physicals		County of Lake	100.00%	5,226	5,226	6
7	V	22 Employee Relations		County of Lake	100.00%	5,300	5,300	7
8	V	21 Indirect A&G Cost Allocation	694,260	County of Lake	100.00%	694,260		8
9	V	19 Legal Fees		County of Lake	100.00%	31,514	31,514	9
10	V	19 Facility Replacement Consultant		County of Lake	100.00%	131,974	131,974	10
11	V	19 Facility Replacement Architect		County of Lake	100.00%	365,647	365,647	11
12	V	19 Consruction Cost Estimator		County of Lake	100.00%	11,830	11,830	12
13	V	06 Mock Up Rooms		County of Lake	100.00%	11,160	11,160	13
14	Total		\$ 4,334,134			\$ 5,313,968	\$ *	979,834 14

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

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	10 Replacement Beds	\$	County of Lake	100.00%	\$ 225,797	\$	225,797	15
16	V	6 Mold Remediation		County of Lake	100.00%	287,367		287,367	16
17	V	26 Liability, Property & Malpractice Ins.		County of Lake	100.00%	337,024		337,024	17
18	V	26 Surety Bond		County of Lake	100.00%	4,500		4,500	18
19	V								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		\$			\$ 854,688	\$ *	854,688	39

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

Facility Name & ID Number

Winchester House

#

0010678

Report Period Beginning:

12/01/08

Ending: 11/30/2009

County of Lake Board Members

Linda Pedersen (District 1)

Diane Hewitt (District 2)

Suzi Schmidt (District 3)

Brent Paxton (District 4)

Bonnie Thomson Carter (District 5)

Melinda Bush (District 6)

Steve Carlson (District 7)

Collin O'Rourke (District 8)

Mary Ross Cunningham (District 9)

Diana O'Kelly (District 10)

Pat Carey (District 11)

Angelo Kyle (District 12)

Susan Loving Gravenhorst (District 13)

Audrey Nixon (District 14)

Carol Calabresa (District 15)

Terry Wilke (District 16)

Stevenson Mountsier (District 17)

Aaron Lawlor (District 18)

Craig Taylor (District 19)

David Stolman (District 20)

Ann B. Maine (District 21)

Michelle Feldman (District 22)

Anne Flanigan Bassi (District 23)

Facility Name & ID Number

Winchester House

#

0010678

Report Period Beginning:

12/01/08

Ending:

11/30/2009

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:

12/01/08

Ending: 1/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

12/01/08

Ending:

11/30/2009

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						\$				\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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.)

Facility Name & ID Number Winchester House

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Report Period Beginning:

12/01/08

Ending:

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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

Facility Name & ID Number Winchester House

0010678

Report Period Beginning:

12/01/08

Ending:

11/30/2009

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					503,847	5
6				1971	(100,596)						6
7				1959	(9,545)						7
8											8
	Improvement Type**										
9	Various		1972		31,454		20	786	786	29,094	9
10	Various		1978		44,855		20	1,121	1,121	34,761	10
11	Various		1982		8,135		20			8,135	11
12	Various		1984		83,196		20	2,708	2,708	67,701	12
13	Various		1986		1,764,063		20			1,764,063	13
14	Various		1987		327,427		20	13,272	13,272	293,932	14
15	Various		1988		61,984		20	464	464	60,128	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	79,654	18
19	Various		1992		73,149		20	2,717	2,717	67,761	19
20	Various		1993		290,100		20	15,342	15,342	245,472	20
21	Various		1994		106,546		20	7,103	7,103	106,546	21
22	Various		1995		246,714		20	15,240	15,240	213,363	22
23	Various		1996		185,343		20	10,740	10,740	139,631	23
24	Various		1997		102,384		20	6,556	6,556	78,679	24
25	Various		1998		184,007		20	11,353	11,353	124,884	25
26	Various		1999		214,009		20	14,214	14,214	142,146	26
27	Various		2000		108,195		20	9,655	9,655	86,899	27
28	Various		2001		237,702		20	8,660	8,660	69,278	28
29	Various		2002		42,369		20	1,733	1,733	12,132	29
30	Various		2003		295,970		20	14,799	14,799	93,185	30
31	Various		2004		90,453		20	4,525	4,525	24,033	31
32	Various		2004		2,431		10	243	243	1,438	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

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Report Period Beginning:

12/01/08

Ending:

11/30/2009

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	Various	2005	\$ 26,040	\$	20	\$ 1,301	\$ 1,301	\$ 6,505	37
38	Replace Fire Hydrant	2006	4,385		20	219	219	767	38
39	Cooling Tower Gear Box and Motor	2006	8,600		20	430	430	1,505	39
40	Cart Wash Room Epoxy	2006	6,228		20	311	311	1,089	40
41	Replace Cubicle Curtains	2006	51,326		20	2,566	2,566	8,981	41
42	Rehabilitation Room Renovation	2006	34,292		20	1,715	1,715	6,003	42
43	Garbage Disposal	2007	3,375		20	169	169	408	43
44	Hydrant Repair	2007	5,983		20	299	299	797	44
45	Chiller Repairs	2007	2,845		20	142	142	343	45
46	Boiler Repair	2007	6,651		20	333	333	999	46
47	Ice-Water Dispenser	2007	2,762		20	138	138	288	47
48	Wardrobe Curtains	2007	2,642		20	132	132	341	48
49	Floor Scrubber	2007	6,980		20	349	349	745	49
50	Elevator Repairs	2007	7,157		20	358	358	1,007	50
51	Water Damage Repair	2007	60,887		20	3,044	3,044	8,618	51
52	Mold Remediation	2008	108,934		20	5,447	5,447	8,116	52
53	Chairs	2008	11,508		20	575	575	623	53
54	Ice makers	2008	11,358		20	568	568	767	54
55	Beauty Salon Countertops	2008	2,727		20	136	136	147	55
56	Rooftop Unit Repairs	2008	86,710		20	4,336	4,336	4,697	56
57	Generator Repair	2008	6,319		20	316	316	474	57
58	Dish Machine Replacement	2008	75,195		20	3,760	3,760	5,327	58
59	Entryway Concrete Repair	2008	20,067		20	1,003	1,003	1,254	59
60	Annuciator Panels	2008	18,550		20	928	928	1,624	60
61	Fire Suppresion System	2008	2,293,006		20	114,650	114,650	229,300	61
62	Kitchen Ceiling Repair	2009	1,465		20	73	73	61	62
63	First Floor Remodeling	2009	16,227		20	811	811	744	63
64	Fourth Floor Remodeling	2009	11,115		20	556	556	278	64
65	Door and Latch Replacement	2009	9,799		20	490	490	204	65
66	Mold Remediation	2009	287,367		20	14,368	14,368	14,368	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,701,096	\$		\$ 437,832	\$ 437,832	\$ 9,421,984	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,783,437	\$	\$ 178,365	\$ 178,365	10	\$ 1,961,802	71
72	Current Year Purchases	371,115		37,112	37,112	10	22,267	72
73	Fully Depreciated Assets	1,333,844					1,333,844	73
74								74
75	TOTALS	\$ 3,488,396	\$	\$ 215,477	\$ 215,477		\$ 3,317,913	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	67,801	77
78	Maintenance	2002 Chevy Truck	2002	30,709					30,709	78
79										79
80	TOTALS			\$ 160,366	\$	\$ 11,451	\$ 11,451		\$ 123,920	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)	\$ 17,355,324	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)	\$ 664,760	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 664,760	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,863,817	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	Buliding - 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	Architects	\$ 365,647	92
93	Model Room Const	11,160	93
94	Const Cost Estimating	11,830	94
95		\$ 388,637	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: \$ 11,501 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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$		\$ 262,135	\$		\$ 262,135	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			99,353			99,353	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			289,401			289,401	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			\$		\$ 650,889	\$		\$ 650,889	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: 12/01/08

Ending: 11/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2009 (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	\$ 8,757,579	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,704,406		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>Taxes Receivable</u>	129,221		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 11,591,206	\$	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)	\$ 11,591,206	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 474,508	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	428,528		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>	211,628		36
37	<u>Public Aid IGT</u>	241,167		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,355,831	\$	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)	\$ 1,355,831	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,225,373	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,581,204	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,103,015	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,103,015	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,122,358	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)	\$ 1,122,358	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)	\$ 10,225,373	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/01/08Ending: 11/30/2009**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	\$ 18,435,704	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,435,704	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	7,812	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	12,492	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,304	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	218,784	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 218,784	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,931,781	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,931,781	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,606,573	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,909,419	31
32	Health Care	9,103,844	32
33	General Administration	5,205,348	33
B. Capital Expense			
34	Ownership	11,501	34
C. Ancillary Expense			
35	Special Cost Centers	650,889	35
36	Provider Participation Fee	197,100	36
D. Other Expenses (specify):			
37	<u>Intergovernmental Transfer</u>	3,406,114	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,484,215	40
41	Income before Income Taxes (line 30 minus line 40)**	1,122,358	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,122,358	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.

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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	1,712	2,080	\$ 103,498	\$ 49.76	1
2	Assistant Director of Nursing	1,792	2,080	83,357	40.08	2
3	Registered Nurses	52,265	62,596	2,116,970	33.82	3
4	Licensed Practical Nurses	16,206	18,704	583,565	31.20	4
5	CNAs & Orderlies	202,638	234,286	3,907,035	16.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,450	1,760	58,397	33.18	9
10	Activity Assistants	21,458	24,515	364,270	14.86	10
11	Social Service Workers	4,287	5,020	130,787	26.05	11
12	Dietician	3,618	4,373	113,556	25.97	12
13	Food Service Supervisor		2,080	91,174	43.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,652	52,453	886,847	16.91	15
16	Dishwashers					16
17	Maintenance Workers	13,335	15,268	492,773	32.27	17
18	Housekeepers	21,713	25,770	451,846	17.53	18
19	Laundry	10,506	12,406	224,074	18.06	19
20	Administrator	1,964	2,080	119,308	57.36	20
21	Assistant Administrator					21
22	Other Administrative	21,709	25,939	642,569	24.77	22
23	Office Manager					23
24	Clerical	6,214	7,709	146,054	18.95	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	3,642	4,278	91,202	21.32	31
32	Other Health Care(specify)					32
33	Other(specify)	9,454	11,099	235,230	21.19	33
34	TOTAL (lines 1 - 33)	438,615	514,496	\$ 10,842,512 *	\$ 21.07	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	5,228	10-03	37
38	Nurse Consultant	143	11,206	10-03	38
39	Pharmacist Consultant	Monthly	8,159	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,948	11-03	44
45	Social Service Consultant	44	2,948	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	316	\$ 50,166		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,520	\$ 219,585	10-03	50
51	Licensed Practical Nurses	2,420	102,116	10-03	51
52	Certified Nurse Assistants/Aides	2,470	53,896	10-03	52
53	TOTAL (lines 50 - 52)	9,410	\$ 375,597		53

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	
Anne Wagner	Administrator	0	\$ 119,308	Workers' Compensation Insurance	\$ 387,078	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	30,105	Advertising: Employee Recruitment	0	
				FICA Taxes	813,261	Health Care Worker Background Check	2,000	
				Employee Health Insurance	1,927,872	(Indicate # of checks performed <u>39</u>)		
				Employee Meals		Patient Background Checks	193 2,000	
				Illinois Municipal Retirement Fund (IMRF)*	898,741	Dues	12,165	
				Employee Physicals	5,226			
				Employee Relations	5,300			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,308	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,067,583		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 16,165	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Construction Cost Systems, Inc	Const. Estimating		\$ 11,830			\$	Out-of-State Travel	\$
Management Performance Assoc	Consultant		131,974					
Plunkett Raysich Architects	Architects		365,647				In-State Travel	2,341
Polsinelli Shugart, P.C.	Legal Fees		7,418					
Wysocki and Smith	Legal Fees		11,367				Seminar Expense	9,693
Swanson, Martin & Bell	Legal Fees		12,729					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 540,965	TOTAL		\$	Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 12,034	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/01/08Ending: 11/30/2009**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 - \$8,510 AAHSA \$1,500 County SNF \$2,500
- (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. \$ 90,051 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. \$ 7,812
- (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: Baker Tilly Virchow Krause, LLP
- (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.

STATE OF ILLINOIS

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Facility Name & ID Number

Winchester House

Supplemental Schedule of Movable Equipment Rental

	Description	Amount
16A	Copy Machines	9,821
16B	Fax Machines	1,056
16C	Postage Machine	624
		<u>11,501</u>

Facility Name & ID Number Winchester House

	Description	Amount
28A	Property Taxes	3,049,828
28B	Transfers from other Funds	1,804,057
28C	All Other Misc.	2,292
28D	Vend Machine Commissions	6,294
28E	Proceeds from Sale of Assets	69,310
		<u>4,931,781</u>

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Facility Name & ID Number

Winchester House

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		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Central Supply	2,501	2,923	\$ 66,430	\$ 22.73	1
2	Nursing Secretarial	5,057	6,096	114,004	18.70	2
3	Marketing (Adj. P5)	1,896	2,080	54,796	26.34	3
		9,454	11,099	235,230		