

Facility Name & ID Number Winchester House

0010678 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,888	2,117	8,178	22,183	8
9	SNF/PED					9
10	ICF	45,664	7,553		53,217	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,552	9,670	8,178	75,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.38%

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 8,178

Medicare Intermediary Wisconsin Physicians Service/Mutual of Omaha

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2010/ Fiscal Year: 11/30/2010

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

Facility Name & ID Number

Winchester House

0010678

Report Period Beginning:

12/01/2009

Ending:

11/30/2010

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	1,055,197	55,801		1,110,998		1,110,998		1,110,998		1
2	Food Purchase		497,212		497,212		497,212	(4,491)	492,721		2
3	Housekeeping	82,481	27,284	409,475	519,240		519,240		519,240		3
4	Laundry	92,439		320,769	413,208		413,208	(1,214)	411,994		4
5	Heat and Other Utilities			456,712	456,712		456,712		456,712		5
6	Maintenance			836,512	836,512		836,512	(12,773)	823,739		6
7	Other (specify):*										7
8	TOTAL General Services	1,230,117	580,297	2,023,468	3,833,882		3,833,882	(18,478)	3,815,404		8
	B. Health Care and Programs										
9	Medical Director			19,677	19,677		19,677		19,677		9
10	Nursing and Medical Records	6,471,027	638,970	832,421	7,942,418		7,942,418		7,942,418		10
10a	Therapy										10a
11	Activities	284,803	12,189	3,216	300,208		300,208		300,208		11
12	Social Services	112,816		3,216	116,032		116,032		116,032		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,868,646	651,159	858,530	8,378,335		8,378,335		8,378,335		16
	C. General Administration										
17	Administrative	125,598			125,598		125,598		125,598		17
18	Directors Fees										18
19	Professional Services							581,648	581,648		19
20	Dues, Fees, Subscriptions & Promotions			13,102	13,102		13,102	(11,816)	1,286		20
21	Clerical & General Office Expenses	822,179	25,623	715,099	1,562,901		1,562,901	(58,716)	1,504,185		21
22	Employee Benefits & Payroll Taxes			3,578,304	3,578,304		3,578,304	380,373	3,958,677		22
23	Inservice Training & Education			2,564	2,564		2,564		2,564		23
24	Travel and Seminar			6,391	6,391		6,391		6,391		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							379,318	379,318		26
27	Other (specify):*										27
28	TOTAL General Administration	947,777	25,623	4,315,460	5,288,860		5,288,860	1,270,807	6,559,667		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,046,540	1,257,079	7,197,458	17,501,077		17,501,077	1,252,329	18,753,406		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:

12/01/2009

Ending:

11/30/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation							527,049	527,049			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			12,057	12,057		12,057		12,057			35
36	Other (specify):*											36
37	TOTAL Ownership			12,057	12,057		12,057	527,049	539,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			535,680	535,680		535,680		535,680			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):*											43
44	TOTAL Special Cost Centers			732,780	732,780		732,780		732,780			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,046,540	1,257,079	7,942,295	18,245,914		18,245,914	1,779,378	20,025,292			45

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

Facility Name & ID Number Winchester House

0010678

Report Period Beginning: 12/01/2009

Ending: 11/30/2010

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	(4,491)	2		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	(1,214)	04		8
9	Non-Straightline Depreciation	527,049	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	(11,816)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(142,672)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 366,856		\$	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)	1,412,522	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,412,522		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,779,378		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: 12/01/2009

Ending: 11/30/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Capitalized Repairs and Maintenance	\$ (71,183)	6	1
2	To Capitalize Current Year Asset Additions	(12,773)	6	2
3	Marketing Wage	(58,716)	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	(142,672)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/2009

Ending:

11/30/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,491)	0	0	0	0	0	0	0	0	0	0	(4,491)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,214)	0	0	0	0	0	0	0	0	0	0	(1,214)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(83,956)	0	71,183	0	0	0	0	0	0	0	0	(12,773)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(89,661)	0	71,183	0	(18,478)	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	581,648	0	0	0	0	0	0	0	0	0	581,648	19
20	Fees, Subscriptions & Promotions	(11,816)	0	0	0	0	0	0	0	0	0	0	(11,816)	20
21	Clerical & General Office Expenses	(58,716)	0	0	0	0	0	0	0	0	0	0	(58,716)	21
22	Employee Benefits & Payroll Taxes	0	380,373	0	0	0	0	0	0	0	0	0	380,373	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	379,318	0	0	0	0	0	0	0	0	379,318	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(70,532)	962,021	379,318	0	1,270,807	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,193)	962,021	450,501	0	1,252,329	29							

STATE OF ILLINOIS

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/2009 Ending:

Summary B

11/30/2010

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	527,049	0	0	0	0	0	0	0	0	0	0	527,049	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	527,049	0	0	0	0	0	0	0	0	0	0	527,049	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	366,856	962,021	450,501	0	1,779,378	45							

Facility Name & ID Number Winchester House

0010678

Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22 Health Life and Dental Insurance	\$ 1,542,024	County of Lake	100.00%	\$ 1,542,024		1
2	V	22 FICA	658,394	County of Lake	100.00%	658,394		2
3	V	22 IMRF	903,764	County of Lake	100.00%	903,764		3
4	V	22 Unemployment Compensation		County of Lake	100.00%	28,215	28,215	4
5	V	22 Worker's Compensation		County of Lake	100.00%	346,482	346,482	5
6	V	22 Employee Physicals		County of Lake	100.00%	5,076	5,076	6
7	V	22 Employee Relations		County of Lake	100.00%	600	600	7
8	V	21 Indirect A&G Cost Allocation	1,510,821	County of Lake	100.00%	1,510,821		8
9	V	19 Legal Fees		County of Lake	100.00%	19,231	19,231	9
10	V	19 Facility Replacement Consultants		County of Lake	100.00%	109,577	109,577	10
11	V	19 Facility Replacement Architect		County of Lake	100.00%	417,395	417,395	11
12	V	19 Construction Cost Estimator		County of Lake	100.00%	12,100	12,100	12
13	V	19 HVAC Engineers		County of Lake	100.00%	23,345	23,345	13
14	Total		\$ 4,615,003			\$ 5,577,024	\$ *	962,021 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	26 Surety Bond	\$	County of Lake	100.00%	\$ 4,500	\$ 4,500	15
16	V	26 Property and Malpractice Insurance		County of Lake	100.00%	374,818	374,818	16
17	V	6 Install Smoke Dampers		County of Lake	100.00%	15,383	15,383	17
18	V	6 Elevator Repair		County of Lake	100.00%	55,800	55,800	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		\$			\$ 450,501	\$ * 450,501	39

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

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)
- Bill Durkin (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: 12/01/2009

Ending:

11/30/2010

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: 12/01/2009

Ending: 1/30/2010

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:

12/01/2009 Ending:

11/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
	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.)

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 2009 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 2010 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:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winchester House COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0010678
 CONTACT PERSON REGARDING THIS REPORT Mary T Stevens
 TELEPHONE 847-377-7236 FAX #: 847-377-7205

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		TOTALS	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly

used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Winchester House

0010678

Report Period Beginning:

12/01/2009 Ending:

11/30/2010

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:

A. Land.

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

Facility Name & ID Number Winchester House

0010678

Report Period Beginning:

12/01/2009 Ending: 11/30/2010

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	\$		\$	\$	\$	4
5			1960	1959	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	29,880	9
10	Various		1978		44,855		20	1,121	1,121	35,882	10
11	Various		1982		8,135		20			8,135	11
12	Various		1984		83,196		20	2,708	2,708	70,409	12
13	Various		1986		1,764,063		20			1,764,063	13
14	Various		1987		327,427		20	13,272	13,272	307,204	14
15	Various		1988		61,984		20	464	464	60,592	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	84,080	18
19	Various		1992		73,149		20	2,717	2,717	70,478	19
20	Various		1993		290,100		20	15,342	15,342	260,814	20
21	Various		1994		106,546		20			106,546	21
22	Various		1995		246,714		20	15,240	15,240	228,603	22
23	Various		1996		185,343		20	10,740	10,740	150,371	23
24	Various		1997		102,384		20	6,556	6,556	85,235	24
25	Various		1998		184,007		20	11,353	11,353	136,237	25
26	Various		1999		214,009		20	14,214	14,214	156,360	26
27	Various		2000		108,195		20	9,655	9,655	96,554	27
28	Various		2001		237,702		20	8,660	8,660	77,938	28
29	Various		2002		42,369		20	1,733	1,733	13,865	29
30	Various		2003		295,970		20	14,799	14,799	107,984	30
31	Various		2004		90,453		20	4,525	4,525	28,558	31
32	Various		2004		2,431		10	243	243	1,681	32
33	Various		2005		26,040		20	1,301	1,301	7,806	33
34	Various		2006		104,831		20	5,241	5,241	23,586	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Garbage Disposal	2007	\$ 3,375	\$	20	\$ 169	\$ 169	\$ 577	37
38	Hydrant Repair	2007	5,983		20	299	299	1,096	38
39	Chiller Repairs	2007	2,845		20	142	142	485	39
40	Boiler Repair	2007	6,651		20	333	333	1,332	40
41	Ice-Water Dispenser	2007	2,762		20	138	138	426	41
42	Wardrobe Curtains	2007	2,642		20	132	132	473	42
43	Floor Scrubber	2007	6,980		20	349	349	1,094	43
44	Elevator Repairs	2007	7,157		20	358	358	1,365	44
45	Water Damage Repair	2007	60,887		20	3,044	3,044	11,662	45
46	Mold Remediation	2008	108,934		20	5,447	5,447	13,563	46
47	Chairs	2008	11,508		20	575	575	1,198	47
48	Ice makers	2008	11,358		20	568	568	1,335	48
49	Beauty Salon Countertops	2008	2,727		20	136	136	283	49
50	Rooftop Unit Repairs	2008	86,710		20	4,336	4,336	9,033	50
51	Generator Repair	2008	6,319		20	316	316	790	51
52	Dish Machine Replacement	2008	75,195		20	3,760	3,760	9,087	52
53	Entryway Concrete Repair	2008	20,067		20	1,003	1,003	2,257	53
54	Annunciator Panels	2008	18,550		20	928	928	2,552	54
55	Fire Suppression System	2008	2,293,006		20	114,650	114,650	343,950	55
56	Kitchen Ceiling Repair	2009	1,465		20	73	73	134	56
57	Cubicle Curtains	2009	6,267		20	313	313	548	57
58	Blinds and Drapes	2009	5,266		20	263	263	504	58
59	Door and Latch Replacement	2009	9,799		20	490	490	694	59
60	Mold Remediation	2009	287,367		20	14,368	14,368	28,736	60
61	Linoleum Replacement	2009	1,929		20	97	97	181	61
62	Paint First Floor	2009	5,552		20	278	278	532	62
63	Paint Fourth Floor	2009	8,328		20	416	416	624	63
64	Install Smoke Dampers	2010	15,383		20	534	534	534	64
65	Elevator Repair	2010	55,800		20	233	233	233	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,772,279	\$		\$ 298,844	\$ 298,844	\$ 4,570,307	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:

12/01/2009

Ending:

11/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,154,452	\$	\$ 215,477	\$ 215,477	10	\$ 2,369,929	71
72	Current Year Purchases	12,773		1,277	1,277	10	1,277	72
73	Fully Depreciated Assets	1,440,390					1,440,390	73
74								74
75	TOTALS	\$ 3,607,615	\$	\$ 216,754	\$ 216,754		\$ 3,811,596	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	\$ 27,185	76
77	Resident Outings	2002 Ford Bus	2002	96,757		9,676	9,676	5	77,477	77
78										78
79										79
80	TOTALS			\$ 129,657	\$	\$ 11,451	\$ 11,451		\$ 104,662	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,515,017	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)	\$ 527,049	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 527,049	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,486,565	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	Architects	\$ 417,395	92
93	Const Cost Estimating	12,100	93
94	HVAC Engineering	23,345	94
95		\$ 452,840	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.

Facility Name & ID Number Winchester House

STATE OF ILLINOIS
0010678

Report Period Beginning: 12/01/2009

Ending: 11/30/2010

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? YES NO

16. Rental Amount for movable equipment: \$ 12,057 Description: Postage Machine = \$468., Fax machines = \$1,056, Copy Machines = \$10,533

(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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
Drop-outs	Completed				
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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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	\$				\$ 179,488	\$			\$ 179,488	1	
2	Licensed Speech and Language Development Therapist	39-03	hrs					123,484				123,484	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-03	hrs					232,708				232,708	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			\$				\$ 535,680	\$			\$ 535,680	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# 0010678Report Period Beginning: 12/01/2009

Ending:

11/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2010

(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	\$ 8,461,542	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,324,387		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>	108,681		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,894,610	\$	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)	\$ 10,894,610	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 812,972	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	307,079		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>	204,987		36
37	<u>Public Aid Audit</u>	250,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,575,038	\$	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)	\$ 1,575,038	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,262,721	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,837,759	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,225,373	1
2	Restatements (describe):		2
3	Reduction in Medicaid Resident Surplus Amount	(401,993)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,823,380	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(560,659)	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)	\$ (560,659)	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)	\$ 9,262,721	24 *

* This must agree with page 17, line 47.

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

Ending:

11/30/2010**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	\$ 13,001,812	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,001,812	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	4,491	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	1,214	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,705	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	81,687	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 81,687	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,596,051	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,596,051	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,685,255	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,833,882	31
32	Health Care	8,378,335	32
33	General Administration	5,288,860	33
B. Capital Expense			
34	Ownership	12,057	34
C. Ancillary Expense			
35	Special Cost Centers	535,680	35
36	Provider Participation Fee	197,100	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,245,914	40
41	Income before Income Taxes (line 30 minus line 40)**	(560,659)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (560,659)	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.

	Description	Amount
28A	Property Taxes	3,012,805
28B	Transfers from Other Funds	1,562,159
28C	All Other Miscellaneous	5,414
28D	Vending Machine Commissions	5,787
28E	Proceeds from Sale of Assets	9,886
		<hr/>
		4,596,051

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/01/2009

Ending:

11/30/2010**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	1,000	1,040	\$ 50,359	\$ 48.42	1
2	Assistant Director of Nursing	952	1,120	41,194	36.78	2
3	Registered Nurses	50,572	56,429	1,988,734	35.24	3
4	Licensed Practical Nurses	16,857	19,042	604,190	31.73	4
5	CNAs & Orderlies	187,376	215,360	3,702,716	17.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,925	2,080	63,174	30.37	9
10	Activity Assistants	14,623	16,712	223,326	13.36	10
11	Social Service Workers	3,929	4,323	118,317	27.37	11
12	Dietician	3,713	4,268	114,643	26.86	12
13	Food Service Supervisor	1,245	1,608	70,478	43.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	42,092	47,773	865,686	18.12	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,764	4,317	89,500	20.73	18
19	Laundry					19
20	Administrator	2,016	2,080	117,563	56.52	20
21	Assistant Administrator					21
22	Other Administrative	18,290	21,164	564,209	26.66	22
23	Office Manager					23
24	Clerical	5,722	6,692	140,061	20.93	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	3,723	4,321	93,815	21.71	31
32	Other Health Care(specify)					32
33	Other(specify)	3,707	4,212	198,575	47.15	33
34	TOTAL (lines 1 - 33)	361,506	412,541	\$ 9,046,540 *	\$ 21.93	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	90	5,545	10-03	37
38	Nurse Consultant	Contract	1,000	10-03	38
39	Pharmacist Consultant	Monthly	7,537	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	3,216	11-03	44
45	Social Service Consultant	44	3,216	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	178	\$ 40,191		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,431	\$ 250,605	10-03	50
51	Licensed Practical Nurses	3,258	123,368	10-03	51
52	Certified Nurse Assistants/Aides	6,334	132,146	10-03	52
53	TOTAL (lines 50 - 52)	15,023	\$ 506,119		53

Facility Name & ID Number

Winchester House

#

0010678

Report Period Beginning

Description	Amount			3		4
	1	2**				
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued		Total Salaries, Wages		Hourly Wage
Central Supply	1,834	2,132	\$	53,632	\$	25.16
Nursing Secretarial	3,988	4,431		86,226		19.46
Marketing (Adj. P5)	1,873	2,080		58,717		28.23
	<u>7,695</u>	<u>8,643</u>		<u>198,575</u>		

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	\$ 125,598	Workers' Compensation Insurance	\$ 346,482	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	28,215	Advertising: Employee Recruitment	60			
				FICA Taxes	680,692	Health Care Worker Background Check	2,910			
				Employee Health Insurance	1,961,676	(Indicate # of checks performed <u>97</u>)				
				Employee Meals	0	Patient Background Checks	150 2,000			
				Illinois Municipal Retirement Fund (IMRF)*	935,936	Dues	13,102			
				Employee Relations	600					
				Employee Physicals	5,076					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,598	TOTAL (agree to Schedule V, line 22, col.8)			\$ 3,958,677	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,062
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	1,726		
							Seminar Expense	4,665		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	Entertainment Expense ()		
C. Professional Services										
Vendor/Payee	Type	Amount								
Management Performance Assoc.	Consultant	\$ 109,577					TOTAL (agree to Sch. V, line 24, col. 8)		\$ 6,391	
Plunkett Raysich Architects	Architects	417,395								
Construction Cost Systems	Const. Estimating	12,100								
Appin Associates Inc.	HVAC Engineering	23,345								
Leaderstat	Interim DON, ADON and Clinical Coordinators	262,928								
Wysocki and Smith	Legal Services	19,231								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 844,576							

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$7,906 AAHSA - \$3,100
- (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. \$ 88,732 Line 10-02
- (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. \$ 4,491
- (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.

2009 2010 Trips & Training

Name	Title	Date	Amount	Description	State
Non Nursing					
David Malinski	HR Generalist	12/15/09	\$100.00	Fingerprinting	IL
A Wagner	Admin	2/25/10	\$57.12	Are you in Compliance with the New Law?	IL
M Purnell	Activities Director	9/14/10	\$100.00	Ill Dementia Care	IL
Marcy Wall	HR Generalist	2/15/10	\$8.33	Stop enabling your employees	IL
Mary Purnell	Activities Director	2/15/10	\$8.33	Stop enabling your employees	IL
	Non Nursing		<u>\$273.78</u>		
Nursing					
N Allimoren	RN	2/23/10	\$13.85	CPR Training	IL
R Tschanz	LPN	2/23/10	\$13.85	CPR Training	IL
C Van Cleave	RN	2/23/10	\$13.85	CPR Training	IL
E Escalante	LPN	2/23/10	\$13.85	CPR Training	IL
R Hewkin	RN	2/23/10	\$13.85	CPR Training	IL
B Nissen	RN	2/23/10	\$13.85	CPR Training	IL
M Cua	RN	2/23/10	\$13.85	CPR Training	IL
M Perkins	RN	2/23/10	\$13.85	CPR Training	IL
S Kindaid	RN	2/23/10	\$13.85	CPR Training	IL
M Vuong	LPN	2/23/10	\$13.80	CPR Training	IL
B Stfer	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
E Lott	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
J Brown	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Myeh	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
J Reeve	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
K Dunlap	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
Diane Pecora	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
S Kindaid	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
F Hill	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
N Dalton	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
N Florio	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
A Benny	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
L Stec	Nursing	7/2/10	\$5.03	Communicating w Residents	IL

I Conpuv	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
S Abraham	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
D Thomas	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
N Alimoren	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
T Rychlik	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
E Estorque	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Frechs	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
P Ames	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
J Arils	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
E Cors	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
T Landres	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
J Dias	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Perez	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Aubrron	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
B Dauglis	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
D Malapitah	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
D Manuel	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
T Zuchniarz	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
F Gargantos	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
R Mangalindan	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
R Stec	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
J Guanzon	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
E Dengui	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Nui	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
M Peruns	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
I Kruii	Nursing	7/2/10	\$4.83	Communicating w Residents	IL
M Vuong	Nursing	7/2/10	\$5.03	Communicating w Residents	IL
R Genotez	Nursing	8/31/10	\$9.56	Safety DVD	IL
D Hamblin	Nursing	8/31/10	\$9.56	Safety DVD	IL
J Paulson	Nursing	8/31/10	\$9.56	Safety DVD	IL
M Mycle	Nursing	8/31/10	\$9.56	Safety DVD	IL
R Tschanz	Nursing	8/31/10	\$9.56	Safety DVD	IL
R Paulson	Nursing	8/31/10	\$9.56	Safety DVD	IL
R Belen	Nursing	8/31/10	\$9.56	Safety DVD	IL
T Rychlik	Nursing	8/31/10	\$9.56	Safety DVD	IL
L Butler	Nursing	8/31/10	\$9.56	Safety DVD	IL
J Fileds	Nursing	8/31/10	\$9.56	Safety DVD	IL
S Kinkaid	Nursing	8/31/10	\$9.56	Safety DVD	IL
J Dinman	Nursing	8/31/10	\$9.56	Safety DVD	IL
M Vuong	Nursing	8/31/10	\$9.56	Safety DVD	IL
D Ramos	Nursing	8/31/10	\$9.56	Safety DVD	IL
P Ames	Nursing	8/31/10	\$9.56	Safety DVD	IL

M Mendoza	Nursing	8/31/10	\$9.56	Safety DVD	IL
N Dottin	Nursing	8/31/10	\$9.56	Safety DVD	IL
B Serrano	Nursing	8/31/10	\$9.43	Safety DVD	IL
V Eapen	RN	10/13-14/10	\$282.50	Best Friends Approach for Dementia	IL
S Kincaid	RN	10/13-14/10	\$282.50	Best Friends Approach for Dementia	IL
J Paulson	RN	10/13-14/10	\$282.50	Best Friends Approach for Dementia	IL
M Schwartz	RN	9/8/10	\$100.00	II Dementia Care Train the Trainer	IL
D Pecoria	RN	8/17-19/10	\$399.00	AANAC Accreditation	WI (within 50 miles)
S Euring	RN	8/17-19/10	\$399.00	AANAC Accreditation	WI (within 50 miles)
J Keever	RN	8/12/10	\$0.00	Lake County Supervisor Skills	IL
D Malapitan	RN	8/12/10	\$0.00	Lake County Supervisor Skills	IL
Emelda Escalente	RN	2/15/10	\$8.33	Stop Enabling your employees	IL
Diane Pecora	RN	2/15/10	\$8.33	Stop Enabling your employees	IL
Loretta Butler	RN	2/15/10	\$8.33	Stop Enabling your employees	IL
A Wagner	RN	2/15/10	\$8.33	Stop Enabling your employees	IL
	Nursing Training		<u>\$2,290.22</u>		
	Total Training		<u>\$2,564.00</u>		

Seminar					
Mary Stevens	CFO	3/10/10	\$11.25	Understand the New Rug IV Rules	IL
Mary Purnell	Activities Director	3/10/10	\$11.25	Understand the New Rug IV Rules	IL
Paula McDonald	Social Worker	3/10/10	\$11.25	Understand the New Rug IV Rules	IL
Jeaneth Woodfield	Social Worker	3/10/10	\$11.25	Understand the New Rug IV Rules	IL
Marcy Wall	HR Generalist	2/25/10	\$19.90	Coaching Skills for Managers	IL
J Diaz	Administrator	2/25/10	\$19.90	Coaching Skills for Mangers	IL
M Purnell	Activities Director	8/10/10	\$288.86	Countdown to MDS 3.0	IL
P McDonald	Socialworker	8/10/10	\$288.86	Countdown to MDS 3.0	IL
J Woodfield	Socialworker	8/10/10	\$288.86	Countdown to MDS 3.0	IL
Marcy Wall	HR Generalist	5/17/10	\$199.00	Firing W/O fear	IL
Joyce Miller	Food Service	5/22/10	\$40.00	McCormick Place	IL
J Miller	Food Service	8/25/10	\$30.00	MDS 3.0 Webinar	IL
				MDS Basics Completion for Positive	
M Purnell	Activities Director	8/24-25/10	\$399.00	Outcomes	IL
K King	Food Service	Aug-10	\$30.00	MDS 3.0 Webinar	IL
Jeaneth Woodfield	Social Worker	5/20/10	\$60.00		IL
	Non Nursing		\$1,709.38		
Marlyn Cua	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
E Escalante	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
D Pecora	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
Loretta Butler	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
Becky Nissen	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
Susan Rio	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
Jeannette Del	RN	2/25/10	\$19.90	Coaching Skills for Managers	IL
Anne Wagner	RN	2/25/10	\$19.90	Coaching Skills for Mangers	IL
Karen Keith	RN		\$288.86	Countdown to MDS 3.0	
S Euring	RN	8/10/10	\$288.86	Countdown to MDS 3.0	IL
J Keever	RN	8/10/10	\$288.85	Countdown to MDS 3.0	IL
D Malapitan	RN	8/10/10	\$288.85	Countdown to MDS 3.0	IL
				MDS Basics Completion for Positive	
J Keever	RN	9/24-25/10	\$399.00	Outcomes	IL
				MDS Basics Completion for Positive	
M Schwartz	RN	9/24-25/10	\$399.00	Outcomes	IL
				MDS Basics Completion for Positive	
D Malapitan	RN	9/24-25/10	\$399.00	Outcomes	IL
				MDS Basics Completion for Positive	
A Wagner	RN	9/25-25/10	\$399.00	Outcomes	IL
Myra Ripley	RN	3/10/10	\$11.25	Understand the New Rug IV Rules	IL
E Escalante	RN	3/10/10	\$11.25	Understanding New Rug IV Rules	IL

L Buttler	RN	3/10/10	\$11.25	Understanding New Rug IV Rules	IL
Anne Wagner	RN	3/10/10	\$11.25	Understanding New Rug IV Rules	IL
	Nursing Training		<u>\$2,955.62</u>		
	Total Training		<u>\$4,665.00</u>		
	Mileage Reimbursement		\$1,726.00		
	Total Travel and Seminar		<u>\$6,391.00</u>		