		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0010678

Facility Name: Winchester House

Address: 1125 N. Milwaukee Ave. (Number) Libertyville (City) 60048 (Zip Code)

County: Lake

Telephone Number: 847-377-7200 **Fax #** 847-377-7205

HFS ID Number:

Date of Initial License for Current Owners: Before 1941

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mary Stevens **Telephone Number:** 847-377-2229
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2010 to 11/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Dave Sorbel
(Title) Interim Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,289	1,540	6,439	19,268	8
9	SNF/PED					9
10	ICF	38,006	8,847		46,853	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,295	10,387	6,439	66,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.32%

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

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 [X] NO [ ]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 360 and days of care provided 6,439

Medicare Intermediary Wisconsis Physician Service/Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [X] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2011 Fiscal Year: 11/30/2011

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,095,487	50,791		1,146,278		1,146,278		1,146,278			1
2	Food Purchase		505,814		505,814		505,814	(3,487)	502,327			2
3	Housekeeping	60,481	27,120	456,715	544,316		544,316		544,316			3
4	Laundry			292,695	292,695		292,695		292,695			4
5	Heat and Other Utilities			473,100	473,100		473,100		473,100			5
6	Maintenance			836,512	836,512		836,512	(105,296)	731,216			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,155,968	583,725	2,059,022	3,798,715		3,798,715	(108,783)	3,689,932			8
	B. Health Care and Programs											
9	Medical Director			19,677	19,677		19,677		19,677			9
10	Nursing and Medical Records	6,194,973	550,060	681,469	7,426,502		7,426,502		7,426,502			10
10a	Therapy											10a
11	Activities	301,571	5,933	2,791	310,295		310,295		310,295			11
12	Social Services	128,176		2,412	130,588		130,588		130,588			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,624,720	555,993	706,349	7,887,062		7,887,062		7,887,062			16
	C. General Administration											
17	Administrative	115,310			115,310		115,310		115,310			17
18	Directors Fees											18
19	Professional Services			640,550	640,550		640,550	121,322	761,872			19
20	Dues, Fees, Subscriptions & Promotions			14,452	14,452		14,452	(6,593)	7,859			20
21	Clerical & General Office Expenses	569,738	25,698	952,608	1,548,044		1,548,044	(53,677)	1,494,367			21
22	Employee Benefits & Payroll Taxes			2,975,868	2,975,868		2,975,868	364,321	3,340,189			22
23	Inservice Training & Education			5,197	5,197		5,197		5,197			23
24	Travel and Seminar			2,837	2,837		2,837		2,837			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							355,011	355,011			26
27	Other (specify):*											27
28	**TOTAL General Administration**	685,048	25,698	4,591,512	5,302,258		5,302,258	780,384	6,082,642			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,465,736	1,165,416	7,356,883	16,988,035		16,988,035	671,601	17,659,636			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:** 12/01/2010 **Ending:** 11/30/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							557,319	557,319			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			11,133	11,133		11,133		11,133			35
36	Other (specify):*											36
37	**TOTAL Ownership**			11,133	11,133		11,133	557,319	568,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			443,232	443,232		443,232		443,232			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**			640,332	640,332		640,332		640,332			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,465,736	1,165,416	8,008,348	17,639,500		17,639,500	1,228,920	18,868,420			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: 12/01/2010 Ending: 11/30/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,487)	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				8
9	Non-Straightline Depreciation	557,319	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	(6,593)	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	(196,857)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 350,382		$	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 Amount	2 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)	878,538		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 878,538		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,228,920		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 Yes	2 No	3 Amount	4 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: 12/01/2010

Ending: 11/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Capitalize Current Year Asset Additions	$ (52,648)	6	1
2	Capitalized Repairs and Maintenance	(90,532)	6	2
3	Marketing Wage	(53,677)	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**	(196,857)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House # 0010678 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,487)	0	0	0	0	0	0	0	0	0	0	(3,487)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(143,180)	0	37,884	0	0	0	0	0	0	0	0	(105,296)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(146,667)	0	37,884	0	0	0	0	0	0	0	0	(108,783)	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	121,322	0	0	0	0	0	0	0	0	0	121,322	19
20	Fees, Subscriptions & Promotions	(6,593)	0	0	0	0	0	0	0	0	0	0	(6,593)	20
21	Clerical & General Office Expenses	(53,677)	0	0	0	0	0	0	0	0	0	0	(53,677)	21
22	Employee Benefits & Payroll Taxes	0	364,321	0	0	0	0	0	0	0	0	0	364,321	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	355,011	0	0	0	0	0	0	0	0	0	355,011	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(60,270)	840,654	0	0	0	0	0	0	0	0	0	780,384	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(206,937)	840,654	37,884	0	0	0	0	0	0	0	0	671,601	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winchester House **#** 0010678 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

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

	Capital Expense / D. Ownership	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)	
30	Depreciation	557,319	0	0	0	0	0	0	0	0	0	0	557,319	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**	557,319	0	0	0	0	0	0	0	0	0	0	557,319	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)**	350,382	840,654	37,884	0	0	0	0	0	0	0	0	1,228,920	45

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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. [X] 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	$ 1,429,952	County of Lake		$ 1,429,952	$	1
2	V	22	FICA	638,236	County of Lake		638,236		2
3	V	22	IMRF	907,680	County of Lake		907,680		3
4	V	22	Unemployment Compensation		County of Lake		24,975	24,975	4
5	V	22	Workers' Compensation		County of Lake		335,242	335,242	5
6	V	22	Employee Physicals		County of Lake		4,104	4,104	6
7	V	19	Certificate of Need Consultant		County of Lake		8,000	8,000	7
8	V	21	Indirect A&G Cost Allocation	1,694,128	County of Lake		1,694,128		8
9	V	19	Legal Fees		County of Lake		11,396	11,396	9
10	V	19	Facility Replacement Consultants		County of Lake		100,051	100,051	10
11	V	19	Facility Replacement Architects		County of Lake		1,875	1,875	11
12	V	26	Surety Bond		County of Lake		4,500	4,500	12
13	V	26	Property and Malpractice Insurance		County of Lake		350,511	350,511	13
14	Total			$ 4,669,996			$ 5,510,650	$ * 840,654	14

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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. [X] 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)	
15	V		6	Elevator Repair	$	County of Lake		$ 19,584	$ 19,584	15
16	V		6	Generator Repair		County of Lake		18,300	18,300	16
17	V									17
18	V									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				$			$ 37,884	$ * 37,884	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)
Jim Newton (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: 12/01/2010 Ending: 11/30/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 12/01/2010 Ending: 1/30/2011

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 [X]

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

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

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

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winchester House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0010678

CONTACT PERSON REGARDING THIS REPORT Mary Stevens

TELEPHONE 847-377-2229 FAX #: 847-377-7205

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 12/01/2010 Ending: 11/30/2011

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? [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	30,666	9
10	Various			1978	44,855		20	1,121	1,121	37,003	10
11	Various			1984	83,196		20	2,708	2,708	73,117	11
12	Various			1987	327,427		20	13,272	13,272	320,476	12
13	Various			1988	61,984		20	464	464	61,056	13
14	Various			1991	88,501		20	4,426	4,426	88,501	14
15	Various			1992	73,149		20	2,717	2,717	73,149	15
16	Various			1993	290,100		20	15,342	15,342	276,156	16
17	Various			1995	246,714		20	15,240	15,240	243,843	17
18	Various			1996	185,343		20	10,740	10,740	161,111	18
19	Various			1997	102,384		20	6,556	6,556	91,791	19
20	Various			1998	184,007		20	11,353	11,353	147,590	20
21	Various			1999	214,009		20	14,214	14,214	170,574	21
22	Various			2000	108,195		20	9,655	9,655	106,209	22
23	Various			2001	237,702		20	8,660	8,660	86,598	23
24	Various			2002	42,369		20	1,733	1,733	15,598	24
25	Various			2003	295,970		20	14,799	14,799	122,783	25
26	Various			2004	90,453		20	4,525	4,525	33,083	26
27	Various			2004	2,431		10	243	243	1,924	27
28	Various			2005	26,040		20	1,301	1,301	9,107	28
29	Various			2006	104,831		20	5,241	5,241	28,827	29
30	Various			2007	99,282		20	4,964	4,964	23,474	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Mold Remediation	2008	$ 108,934	$	20	$ 5,447	$ 5,447	$ 19,010	37
38	Chairs	2008	11,508		20	575	575	1,773	38
39	Ice makers	2008	11,358		20	568	568	1,903	39
40	Beauty Salon Countertops	2008	2,727		20	136	136	419	40
41	Rooftop Unit Repairs	2008	86,710		20	4,336	4,336	13,369	41
42	Generator Repair	2008	6,319		20	316	316	1,106	42
43	Dish Machine Replacement	2008	75,195		20	3,760	3,760	12,847	43
44	Entryway Concrete Repair	2008	20,067		20	1,003	1,003	3,260	44
45	Annuciator Panels	2008	18,550		20	928	928	3,480	45
46	Fire Suppresion System	2008	2,293,006		20	114,650	114,650	458,600	46
47	Kitchen Ceiling Repair	2009	1,465		20	73	73	207	47
48	Cubicle Curtains	2009	6,267		20	313	313	861	48
49	Blinds and Drapes	2009	5,266		20	263	263	767	49
50	Door and Latch Replacement	2009	9,799		20	490	490	1,184	50
51	Mold Remediation	2009	287,367		20	14,368	14,368	43,104	51
52	Linoleum Replacement	2009	1,929		20	97	97	278	52
53	Paint First Floor	2009	5,552		20	278	278	810	53
54	Paint Fourth Floor	2009	8,328		20	416	416	1,040	54
55	Install Smoke Dampers	2010	15,383		20	769	769	1,303	55
56	Elevator Repair	2010	55,800		20	2,790	2,790	3,023	56
57	Resident Lifts	2011	23,786		10	4,955	4,955	4,955	57
58	Resident Lifts	2011	17,828		10	115	115	115	58
59	Bladder Scan	2011	11,034		10	242	242	242	59
60	Elevator Repair	2011	19,584		20	16,320	16,320	16,320	60
61	Generator Repair	2011	18,300		20	534	534	534	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,761,899	$		$ 323,802	$ 323,802	$ 2,793,146	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: 12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 2,167,225	$	$ 216,754	$ 216,754	10	$ 2,383,979	71
72	Current Year Purchases	52,648		5,312	5,312	10	5,312	72
73	Fully Depreciated Assets	2,262,562						73
74								74
75	TOTALS	$ 4,482,435	$	$ 222,066	$ 222,066		$ 2,389,291	75

D. Vehicle Costs. (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	$ 28,960	76
77	Resident Outings	2002 Ford Bus	2002	96,757		9,676	9,676	5	87,153	77
78										78
79										79
80	TOTALS			$ 129,657	$	$ 11,451	$ 11,451		$ 116,113	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,379,457	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)	$ 557,319	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 557,319	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,298,550	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	Certificate Of Need Consultant	$ 8,000	92
93	Architects	1,875	93
94			94
95		$ 9,875	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 # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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: _____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 11,133 Description: Fax Machines = $1,056, Copy Machines = $10,077
(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

* 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.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 184,134	$		$ 184,134	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			126,070			126,070	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			134,028			134,028	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 444,232	$		$ 444,232	14

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

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,255,669	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,445,721		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): Taxes Receivable	597,726		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,299,116	$	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)**	$ 9,299,116	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,143,759	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	346,574		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	Deposits Payable	316,980		36
37	Public Aid Audit	250,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,057,313	$	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)**	$ 2,057,313	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,668,107	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,725,420	$	48

*(See instructions.)

Facility Name & ID Number Winchester House **#** 0010678 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,262,721	1
2	Restatements (describe):		2
3	Increase in Accrual	56,851	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,319,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,651,465)	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)**	$ (2,651,465)	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)**	$ 6,668,107	24 *

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

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,639,298	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,639,298	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	3,931	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		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,931	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,354	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,354	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		3,325,452	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,325,452	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,988,035	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,798,715	31
32	Health Care	7,887,062	32
33	General Administration	5,302,258	33
	B. Capital Expense		
34	Ownership	11,133	34
	C. Ancillary Expense		
35	Special Cost Centers	443,232	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)***	$ 17,639,500	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,651,465)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,651,465)	43

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

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

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

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

Facility Name & ID Number Winchester House **#** 0010678 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

	Description	Amount
28A	Property Taxes	1,723,652
28B	Transfers from Other Funds	1,598,039
28C	All Other Miscellaneous	1,046
28D	Vending Machine Commissions	2,715
		3,325,452

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	16	16	$ 711	$ 44.44	1
2	Assistant Director of Nursing	1,272	1,408	48,364	34.35	2
3	Registered Nurses	40,182	54,883	1,613,670	29.40	3
4	Licensed Practical Nurses	13,250	18,028	529,203	29.35	4
5	CNAs & Orderlies	175,707	226,186	3,662,587	16.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,628	3,765	71,873	19.09	9
10	Activity Assistants	13,321	16,610	219,909	13.24	10
11	Social Service Workers	3,583	4,959	125,061	25.22	11
12	Dietician	3,431	5,011	125,071	24.96	12
13	Food Service Supervisor	2,100	2,512	91,288	36.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,226	60,993	951,820	15.61	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,314	3,088	57,718	18.69	18
19	Laundry					19
20	Administrator	2,040	2,080	115,316	55.44	20
21	Assistant Administrator					21
22	Other Administrative	18,152	24,099	509,824	21.16	22
23	Office Manager					23
24	Clerical	5,267	7,150	137,356	19.21	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	2,043	2,673	52,648	19.70	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,739	7,922	153,316	19.35	33
34	TOTAL (lines 1 - 33)	335,271	441,383	$ 8,465,735 *	$ 19.18	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	19,677	09-03	36
37	Medical Records Consultant	86	5,356	10-03	37
38	Nurse Consultant	9	612	10-03	38
39	Pharmacist Consultant	Monthly	2,340	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	36	2,412	11-03	44
45	Social Service Consultant	36	2,412	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	167	$ 32,809		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,536	$ 388,978	10-03	50
51	Licensed Practical Nurses	3,386	141,237	10-03	51
52	Certified Nurse Assistants/Aides	2,319	49,265	10-03	52
53	TOTAL (lines 50 - 52)	14,241	$ 579,480		53

Facility Name & ID Number Winchester House # 0010678 **Report Period Beginning:** 12/01/2010 **Ending:** 11/30/2011

Description	Amount 1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage
Central Supply	1,676	2,724	$ 62,257	$ 22.85
Nursing Secretarial	1,879	2,465	37,382	15.17
Marketing (Adj. P5)	2,184	2,733	53,677	19.64
	5,739	7,922	153,316	

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anne Wagner	Administrator	0	$ 115,310
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 115,310

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Management Performance Assoc.	Consultant	$ 100,051
Plunkett Raysich Architects	Architects	1,875
Leaderstat	Interim DON	13,497
Pathways	Interim DON	627,053
	MDS and Clinical Coordinators	
Charles Foley and Assoc.	Certificate of Need Consultant	8,000
Wysocki and Smith	Legal Services	11,396
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 761,872

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 335,243
Unemployment Compensation Insurance	24,975
FICA Taxes	638,236
Employee Health Insurance	1,429,952
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	907,680
Employee Physicals	4,104
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,340,190

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 18)	540
Patient Background Checks 97	1,000
Dues	10,922
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,452

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	1,458
Seminar Expense	1,379
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,837

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

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 - $7,822 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. $ **76,218** 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. $ **3,487**

(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

2010 2011 Trips & Training

Name	Title	Date	Amount	Description	State	
Non-Nurisng	Title	Date	Amount	Description	IL	Non IL
M Purnell	Activities Director	12/17/11	$69.90	Health Care Dementia	IL	
Staff Training	Activities Aids	1/10/11	$180.00	Specialized Workshop	IL	
Activity Aid	Activities Aid	1/10/11	$60.00	Greek American Rehab	IL	
M Wall	Human Resources	4/21/11	$39.95	Dementia Care Training Program	IL	
M Wall	Human Resources	7/19/11	$99.00	Il Workers' Compensation Reform	IL	
B King	Dietitition	6/24/11	$60.00	Health Care communities	IL	
M Purnell	Activities Director	8/24/11	$39.95	Dementia Care Training Program	IL	
B King	Dietitition	8/31/11	$110.00	Redefining the future	IL	
M Purnell	Activities Director	9/12/11	$130.00	World Hlzheimer's Day	IL	
M Wall	Human Resources	9/28/11	$551.00	Nursing training DVD's	IL	
M Wall	Human Resources	9/21/11	$39.95	Dementia Care Training Program	IL	
M Wall	Human Resources	11/17/11	$201.00	Video training for nurses	IL	

Name Nursing	Title	Date	Amount	Description	Illinois	Non IL
A Wagner	Administrator	2/28/11	$169.00	What every NHA needs MDS 3.0		WI (within 10 miles of border)
A Wagner	Administrator	3/11/11	$149.00	Infection Control & Prevention	IL	
J Koczwara	RN	3/18/11	$39.95	Alz Dem Care Practice Recommendations	IL	
A Wagner	Administrator	5/3/11	$99.00	Evidence Based Practice in Nursing	IL	
A Wagner	Administrator	6/20/11	$550.00	Medicare Unitversity	IL	
A Wagner	Administrator	6/16/11	$169.00	What every NHA needs to know MDS 3.0		WI (within 10 miles of border)
?	?	7/11/11	$169.00	What every NHA needs to know MDS 3.0		WI (within 10 miles of border)
A Wagner	Administrator	8/15/11	$100.00	Guidance for reporting crimes against nursing	IL	
	nursing	8/24/11	$39.95	Dementia Training	IL	
??	??	9/9/11	-$169.00	Credit for seminar		
S Kincaid	LPN	10/4/11	$39.95	Dementia Training	IL	
?	nursing	10/4/11	$39.95	Dementia Training	IL	
A Wagner	Administrator	9/23/11	$2,656.80	Healthy advice communication	IL	
D Davis	nursing	10/4/11	$39.95	Dementia Training	IL	
A Wagner	Administrator	10/24/11	$99.00	LSN Webinar	IL	
A Wagner	Administrator	10/27/11	$135.00	INHAA registration	IL	
A Wagner	Administrator	11/4/11	$50.00	INHHA conference	IL	
A Teck	nursing	11/23/11	$180.00	CPR training	IL	
A teck	nursing	11/23/11	$90.00	CPR training	IL	