

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0010678</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Winchester House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/2011</u> to <u>11/30/2012</u> 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.																							
Address: <u>1125 North Milwaukee Avenue</u> <u>Libertyville</u> <u>60048</u>																									
Number City Zip Code																									
County: <u>Lake</u>																									
Telephone Number: <u>847-377-7200</u> Fax # <u>847-377-7205</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Noreen Zaio</u></td><td></td></tr><tr><td>(Title) <u>Interim Administrator</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Stephanie Cyrus</u> <u>Senior Financial Consultant</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>Health Dimensions Group</u> <u>4400 Baker Road, Suite 100 Minneapolis, MN 55343</u></td><td></td></tr><tr><td>(Telephone) <u>763-537-5700</u> Fax # <u>763-537-9200</u></td><td></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Noreen Zaio</u>		(Title) <u>Interim Administrator</u>		(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) <u>Stephanie Cyrus</u> <u>Senior Financial Consultant</u>		(Firm Name & Address) <u>Health Dimensions Group</u> <u>4400 Baker Road, Suite 100 Minneapolis, MN 55343</u>		(Telephone) <u>763-537-5700</u> Fax # <u>763-537-9200</u>		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					
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Date of Initial License for Current Owners: <u>Before 1941</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☒ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☒ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Stephanie Cyrus</u> Telephone Number: <u>763-225-8638</u>																									
Email Address: _____																									

Facility Name & ID Number Winchester House# 0010678 Report Period Beginning: 12/1/2011 Ending: 11/30/2012

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	<u>360</u>	Skilled (SNF)	<u>360</u>	<u>131,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>360</u>	TOTALS	<u>360</u>	<u>131,760</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,208</u>	<u>1,551</u>	<u>6,748</u>	<u>15,507</u>	8
9	SNF/PED					9
10	ICF	<u>35,385</u>	<u>11,162</u>		<u>46,547</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,593</u>	<u>12,713</u>	<u>6,748</u>	<u>62,054</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 47.10%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1941

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

YES ☐ Date _____ NO ☒

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

YES ☒ NO ☐ If YES, enter number
of beds certified 360 and days of care provided 6,527Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 11/30/2012 Fiscal Year: 11/30/2012

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

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		59,802	1,087,395	1,147,197		1,147,197	16,974	1,164,171			1
2	Food Purchase		510,520		510,520		510,520	(3,209)	507,311			2
3	Housekeeping		25,246	479,914	505,160		505,160		505,160			3
4	Laundry		106	359,318	359,424		359,424	1,078	360,502			4
5	Heat and Other Utilities			400,331	400,331		400,331		400,331			5
6	Maintenance		293	846,946	847,239		847,239	1,751	848,990			6
7	Other (specify):*											7
8	TOTAL General Services		595,967	3,173,904	3,769,871		3,769,871	16,594	3,786,465			8
	B. Health Care and Programs											
9	Medical Director			19,677	19,677		19,677		19,677			9
10	Nursing and Medical Records		244,685	7,200,827	7,445,512		7,445,512	101,894	7,547,406			10
10a	Therapy											10a
11	Activities		6,289	306,027	312,316		312,316	5,025	317,341			11
12	Social Services			148,104	148,104		148,104	2,301	150,405			12
13	CNA Training			2,063	2,063		2,063		2,063			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs		250,974	7,676,698	7,927,672		7,927,672	109,220	8,036,892			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			824,627	824,627		824,627	(45,213)	779,414			19
20	Dues, Fees, Subscriptions & Promotions			9,904	9,904		9,904		9,904			20
21	Clerical & General Office Expenses		21,974	1,599,425	1,621,399		1,621,399	(126,826)	1,494,573			21
22	Employee Benefits & Payroll Taxes			146,668	146,668		146,668		146,668			22
23	Inservice Training & Education			780	780		780		780			23
24	Travel and Seminar			38,289	38,289		38,289		38,289			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			232,978	232,978		232,978		232,978			26
27	Other (specify):*											27
28	TOTAL General Administration		21,974	2,852,671	2,874,645		2,874,645	(172,039)	2,702,606			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)		868,915	13,703,273	14,572,188		14,572,188	(46,225)	14,525,963			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation											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			16,038	16,038		16,038		16,038			35
36	Other (specify):*			6,745	6,745		6,745	(6,745)				36
37	TOTAL Ownership			22,783	22,783		22,783	(6,745)	16,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,259	992,087	1,009,346		1,009,346		1,009,346			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			521,803	521,803		521,803		521,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,259	1,513,890	1,531,149		1,531,149		1,531,149			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)		886,174	15,239,946	16,126,120		16,126,120	(52,970)	16,073,150			45

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

		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	(3,209)	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				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	(45,213)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,009)	21		24
25	Fund Raising, Advertising and Promotional	(64,402)	21		25
	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	136,863			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,970)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (52,970)		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: 12/1/2011

Ending: 11/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous Income	\$ (1,620)	21	1
2	Remove Capitalized Expenses	(6,745)	36	2
3	Worker's Compensation Adjustment	101,894	10	3
4	Worker's Compensation Adjustment	5,025	11	4
5	Worker's Compensation Adjustment	2,301	12	5
6	Worker's Compensation Adjustment	16,974	1	6
7	Worker's Compensation Adjustment	1,078	4	7
8	Worker's Compensation Adjustment	1,751	6	8
9	Worker's Compensation Adjustment	16,205	21	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	136,863		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House# 0010678

Report Period Beginning:

12/1/2011

Ending:

11/30/2012

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	16,974	0	0	0	0	0	0	0	0	0	0	16,974	1
2	Food Purchase	(3,209)	0	0	0	0	0	0	0	0	0	0	(3,209)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	1,078	0	0	0	0	0	0	0	0	0	0	1,078	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,751	0	0	0	0	0	0	0	0	0	0	1,751	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	16,594	0	0	0	0	0	0	0	0	0	0	16,594	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	101,894	0	0	0	0	0	0	0	0	0	0	101,894	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	5,025	0	0	0	0	0	0	0	0	0	0	5,025	11
12	Social Services	2,301	0	0	0	0	0	0	0	0	0	0	2,301	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	109,220	0	0	0	0	0	0	0	0	0	0	109,220	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	(45,213)	0	0	0	0	0	0	0	0	0	0	(45,213)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(126,826)	0	0	0	0	0	0	0	0	0	0	(126,826)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(172,039)	0	0	0	0	0	0	0	0	0	0	(172,039)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,225)	0	0	0	0	0	0	0	0	0	0	(46,225)	29

STATE OF ILLINOIS

Facility Name & ID Number Winchester House

0010678

Report Period Beginning:

12/1/2011 Ending:

Summary B
11/30/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(6,745)	0	0	0	0	0	0	0	0	0	0	(6,745)	36
37	TOTAL Ownership	(6,745)	0	0	0	0	0	0	0	0	0	0	(6,745)	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)	(52,970)	0	0	0	0	0	0	0	0	0	0	(52,970)	45

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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Indirect A&G cost Allocation	\$ 275,575	County of Lake		\$ 275,575	\$	1
2	V	6	Maintenance allocation	767,945	County of Lake		767,945		2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,043,520			\$ 1,043,520	\$ *	14

* 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)
- Tom Weber (District 3)
- Brent Paxton (District 4)
- Bonnie Thomson Carter (District 5)
- Pat Carey (District 6)
- Steve Carlson (District 7)
- Bill Durkin (District 8)
- Mary Ross Cunningham (District 9)
- Diana O'Kelly (District 10)
- Steve Mandel (District 11)
- S. Michael Rummel (District 12)
- Sandra Hart (District 13)
- Audrey Nixon (District 14)
- Carol Calabresa (District 15)
- Terry Wilke (District 16)
- Nick Sauer (District 17)
- Aaron Lawlor (District 18)
- Craig Taylor (District 19)
- David Stolman (District 20)
- Ann B. Maine (District 21)

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/1/2011 Ending: 11/30/2012

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:	12/1/2011	Ending:	1/30/2012
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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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Winchester House</u>	COUNTY	<u>Lake</u>
---------------	-------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0010678

CONTACT PERSON REGARDING THIS REPORT Stephanie Cyrus

TELEPHONE 763-225-8638 FAX #: 763-537-9200

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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.		\$	\$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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		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:

12/1/2011

Ending:

11/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			31,454	9	
10	Various			1978	44,855		20	1,121	1,121	38,124	10	
11	Various			1984	83,196		20	2,708	2,708	75,825	11	
12	Various			1987	327,427		20			327,427	12	
13	Various			1988	61,984		20	464	464	61,520	13	
14	Various			1991	88,501		20			88,501	14	
15	Various			1992	73,149		20			73,149	15	
16	Various			1993	290,100		20			290,100	16	
17	Various			1995	246,714		20	2,871	2,871	246,714	17	
18	Various			1996	185,343		20	10,740	10,740	171,851	18	
19	Various			1997	102,384		20	6,556	6,556	98,347	19	
20	Various			1998	184,007		20	11,353	11,353	158,943	20	
21	Various			1999	214,009		20	14,214	14,214	184,788	21	
22	Various			2000	108,195		20	1,986	1,986	108,195	22	
23	Various			2001	237,702		20	8,660	8,660	95,258	23	
24	Various			2002	42,369		20	1,733	1,733	17,331	24	
25	Various			2003	295,970		20	14,799	14,799	137,582	25	
26	Various			2004	90,453		20	4,525	4,525	37,608	26	
27	Various			2004	2,431		10	243	243	2,167	27	
28	Various			2005	26,040		20	1,301	1,301	10,408	28	
29	Various			2006	104,831		20	5,241	5,241	34,068	29	
30	Various			2007	99,282		20	4,964	4,964	28,438	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:

12/1/2011

Ending:

11/30/2012

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	\$ 24,457	37
38	Chairs	2008	11,508		20	575	575	2,348	38
39	Ice makers	2008	11,358		20	568	568	2,471	39
40	Beauty Salon Countertops	2008	2,727		20	136	136	555	40
41	Rooftop Unit Repairs	2008	86,710		20	4,336	4,336	17,705	41
42	Generator Repair	2008	6,319		20	316	316	1,422	42
43	Dish Machine Replacement	2008	75,195		20	3,760	3,760	16,607	43
44	Entryway Concrete Repair	2008	20,067		20	1,003	1,003	4,263	44
45	Annuciator Panels	2008	18,550		20	928	928	4,408	45
46	Fire Suppression System	2008	2,293,006		20	114,650	114,650	573,250	46
47	Kitchen Ceiling Repair	2009	1,465		20	73	73	280	47
48	Cubicle Curtains	2009	6,267		20	313	313	1,174	48
49	Blinds and Drapes	2009	5,266		20	263	263	1,030	49
50	Door and Latch Replacement	2009	9,799		20	490	490	1,674	50
51	Mold Remediation	2009	287,367		20	14,368	14,368	57,472	51
52	Linoleum Replacement	2009	1,929		20	97	97	375	52
53	Paint First Floor	2009	5,552		20	278	278	1,088	53
54	Paint Fourth Floor	2009	8,328		20	416	416	1,456	54
55	Install Smoke Dampers	2010	15,383		20	769	769	2,072	55
56	Elevator Repair	2010	55,800		20	2,790	2,790	5,813	56
57	Resident Lifts	2011	23,786		10	4,955	4,955	9,910	57
58	Resident Lifts	2011	17,828		10	115	115	230	58
59	Bladder Scan	2011	11,034		10	242	242	484	59
60	Elevator Repair	2011	19,584		20	3,264	3,264	19,584	60
61	Generator Repair	2011	18,300		20	534	534	1,068	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	\$		\$ 254,165	\$ 254,165	\$ 3,068,994	70

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

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	\$2,219,873	\$	\$222,066	\$222,066	10	\$2,611,357	71
72	Current Year Purchases	6,745		850	850	15, 5	850	72
73	Fully Depreciated Assets	2,262,562						73
74								74
75	TOTALS	\$4,489,180	\$	\$222,916	\$222,916		\$2,612,207	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	\$30,735	76
77	Resident Outings	2002 Ford Bus	2002	96,757		9,604	9,604	5	96,757	77
78										78
79										79
80	TOTALS			\$129,657	\$	\$11,379	\$11,379		\$127,492	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)	\$16,386,202	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)	\$488,460	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$488,460	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,808,693	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building-1960	\$180,634	\$	\$180,634	86
87					87
88					88
89					89
90					90
91	TOTALS	\$180,634	\$	\$180,634	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$16,038
- Description: Copier= \$5,520, Water cooler=\$4,080, Beds=\$780, Service plan =\$5,658
- (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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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		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	\$		\$ 333,116	\$		\$ 333,116	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			48,799			48,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			377,348			377,348	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				195,947		195,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab, X-Ray, Other Medicare A			54,136					54,136	12
13	Other (specify):									13
14	TOTAL			\$ 54,136		\$ 759,263	\$ 195,947		\$ 1,009,346	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.

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	\$ 1,972,096	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 317,275)	8,137,163		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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,109,259	\$	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)	\$ 10,109,259	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,623,990	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(62,247)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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	174,965		36
37	Unearned Revenue	1,015,069		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,751,777	\$	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)	\$ 2,751,777	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,357,482	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,109,259	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,668,107	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,668,107	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	689,373	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)	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 689,375	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)	\$ 7,357,482	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winchester House# 0010678Report Period Beginning: 12/1/2011Ending: 11/30/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,995,724	1
2	Discounts and Allowances for all Levels	(2,595,985)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,399,739	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	3,209	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)	\$ 3,209	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,493	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,493	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income/Property Tax Revenue	3,033,912	28
28a	Transfers from Other Funds	1,372,140	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,406,052	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,815,493	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,769,871	31
32	Health Care	7,927,672	32
33	General Administration	2,874,645	33
	B. Capital Expense		
34	Ownership	22,783	34
	C. Ancillary Expense		
35	Special Cost Centers	1,009,346	35
36	Provider Participation Fee	521,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,126,120	40
41	Income before Income Taxes (line 30 minus line 40)**	689,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 689,373	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,379,997	44
45	Private Pay - Net Inpatient Revenue	2,060,957	45
46	Medicare - Net Inpatient Revenue	3,316,953	46
47	Other-(specify) <u>Managed Care</u>	107,900	47
48	Other-(specify) <u>Prior Year Revenue</u>	533,932	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,399,739	49

* 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.

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	1,528	1,744	\$ 86,507	\$ 49.60	1
2	Assistant Director of Nursing	848	880	32,340	36.75	2
3	Registered Nurses	43,571	45,691	1,530,975	33.51	3
4	Licensed Practical Nurses	19,184	20,184	564,697	27.98	4
5	CNAs & Orderlies	148,851	157,038	2,399,286	15.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,178	12,788	178,503	13.96	10
11	Social Service Workers	3,941	4,278	108,583	25.38	11
12	Dietician	2,137	2,284	62,996	27.58	12
13	Food Service Supervisor	1,965	2,072	75,110	36.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,196	47,163	667,912	14.16	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,968	2,072	50,983	24.61	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	10,585	11,266	570,642	50.65	22
23	Office Manager					23
24	Clerical	15,071	16,155	332,594	20.59	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					31
32	Other Health Care(specify)	8,215	8,951	159,137	17.78	32
33	Other(specify)	817	869	16,956	19.51	33
34	TOTAL (lines 1 - 33)	315,055	333,435	\$ 6,837,221 *	\$ 20.51	34

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		2,345	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,964	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		3,984	11-03	44
45	Social Service Consultant		2,760	12-03	45
46	Other(specify) <u>Clinical Nurse/MDS</u>		193,570	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 225,300		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,071	\$ 379,943	10-3	50
51	Licensed Practical Nurses	3,064	124,657	10-3	51
52	Certified Nurse Assistants/Aides	3,150	88,764	10-3	52
53	TOTAL (lines 50 - 52)	14,285	\$ 593,364		53

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

** See instructions.

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	
			\$	Workers' Compensation Insurance		\$ 340,231	IDPH License Fee	\$	
All in purchased services				Unemployment Compensation Insurance		136,107	Advertising: Employee Recruitment		
				FICA Taxes		477,543	Health Care Worker Background Check		
				Employee Health Insurance		1,053,847	(Indicate # of checks performed)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Life Services Network	9,825	
				Life, LTD, AD&D		6,813	Amazon Prime	79	
				Transfer Out		(14,884)			
				PTO		289,919			
				Dental		39,055			
				Other		1,917			

*** 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	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

Life Services \$6,725, LeadingAge \$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.

\$ 75,532

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.

\$ 521,803

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.

\$ 3,209
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

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?

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 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?

No disallowed

Attach invoices and a summary of services for all architect and appraisal fees.