FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0054049

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: 12/14/2015

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler **Telephone Number:** (847) 374 - 0400
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 1/1/2016 to 12/31/2016 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)
(Title)

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK,LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 374 - 0400 Fax # (847) 374 - 0420

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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 N/A

	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	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,947	5,761	21,483	50,191	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,947	5,761	21,483	50,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.39%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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 12/14/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/14/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 224 and days of care provided 2,725

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31 Fiscal Year: 12/31

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	527,800	18,020		545,820		545,820		545,820			1
2	Food Purchase		343,776		343,776		343,776		343,776			2
3	Housekeeping	54,232	32,840	364,232	451,304		451,304		451,304			3
4	Laundry		21,842	175,972	197,814		197,814		197,814			4
5	Heat and Other Utilities			248,622	248,622		248,622		248,622			5
6	Maintenance	90,879		25,710	116,589		116,589		116,589			6
7	Other (specify):*											7
8	TOTAL General Services	672,911	416,478	814,536	1,903,925		1,903,925		1,903,925			8
	B. Health Care and Programs											
9	Medical Director			17,600	17,600		17,600		17,600			9
10	Nursing and Medical Records	4,156,888	265,086	39,681	4,461,655		4,461,655		4,461,655			10
10a	Therapy	70,732			70,732		70,732		70,732			10a
11	Activities	171,373	3,668	1,104	176,145		176,145		176,145			11
12	Social Services	146,290		552	146,842		146,842		146,842			12
13	CNA Training											13
14	Program Transportation			4,795	4,795		4,795		4,795			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,545,283	268,754	63,732	4,877,769		4,877,769		4,877,769			16
	C. General Administration											
17	Administrative	118,081		523,415	641,496		641,496	(507,132)	134,364			17
18	Directors Fees											18
19	Professional Services			325,815	325,815		325,815	(73,213)	252,602			19
20	Dues, Fees, Subscriptions & Promotions			127,662	127,662		127,662	(5,563)	122,099			20
21	Clerical & General Office Expenses	412,244	220,502	217,907	850,653		850,653	578,172	1,428,825			21
22	Employee Benefits & Payroll Taxes			2,164,641	2,164,641		2,164,641		2,164,641			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,270	24,270		24,270	10,899	35,169			24
25	Other Admin. Staff Transportation							47,740	47,740			25
26	Insurance-Prop.Liab.Malpractice			158,840	158,840		158,840	15,195	174,035			26
27	Other (specify):*							183,206	183,206			27
28	TOTAL General Administration	530,325	220,502	3,542,550	4,293,377		4,293,377	249,304	4,542,681			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,748,519	905,734	4,420,818	11,075,071		11,075,071	249,304	11,324,375			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 #0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			9,741	9,741		9,741	(4,667)	5,074			30
31	Amortization of Pre-Op. & Org.			1,117	1,117		1,117		1,117			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			316,000	316,000		316,000	14,789	330,789			34
35	Rent-Equipment & Vehicles			6,659	6,659		6,659		6,659			35
36	Other (specify):*											36
37	**TOTAL Ownership**			333,517	333,517		333,517	10,122	343,639			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	619,171	169,504	54,853	843,528		843,528		843,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			409,141	409,141		409,141		409,141			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	619,171	169,504	463,994	1,252,669		1,252,669		1,252,669			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,367,690	1,075,238	5,218,329	12,661,257		12,661,257	259,426	12,920,683			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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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				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	(4,998)	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	(187,942)	21		24
25	Fund Raising, Advertising and Promotional	(8,491)	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	(101,132)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (302,563)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (302,563)		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# 0054049

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal Fees	$ (50,643)	19	1
2	Bank Fees	(6,030)	21	2
3	Non-Allowable Penalty Interest	(956)	21	3
4	Marketing Director Wages	(15,960)	21	4
5	Marketing Consultant	(26,661)	19	5
6	Non-Allowable Travel - Mktg Mileage	(882)	24	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**	(101,132)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House **#** 0054049 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	(507,132)	0	0	0	0	0	0	0	0	0	(507,132)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(77,304)	4,091	0	0	0	0	0	0	0	0	0	(73,213)	19
20	Fees, Subscriptions & Promotions	(8,491)	2,928	0	0	0	0	0	0	0	0	0	(5,563)	20
21	Clerical & General Office Expenses	(210,888)	789,060	0	0	0	0	0	0	0	0	0	578,172	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	(882)	11,781	0	0	0	0	0	0	0	0	0	10,899	24
25	Other Admin. Staff Transportation	0	47,740	0	0	0	0	0	0	0	0	0	47,740	25
26	Insurance-Prop.Liab.Malpractice	0	15,195	0	0	0	0	0	0	0	0	0	15,195	26
27	Other (specify):*	0	183,206	0	0	0	0	0	0	0	0	0	183,206	27
28	**TOTAL General Administration**	(297,565)	546,869	0	0	0	0	0	0	0	0	0	249,304	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(297,565)	546,869	0	0	0	0	0	0	0	0	0	249,304	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winchester House **#** 0054049 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,998)	331	0	0	0	0	0	0	0	0	0	(4,667)	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	14,789	0	0	0	0	0	0	0	0	0	14,789	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**	(4,998)	15,120	0	0	0	0	0	0	0	0	0	10,122	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)**	(302,563)	561,989	0	0	0	0	0	0	0	0	0	259,426	45

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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
				Transitional Care Mangement		Management Co.
IHOP JV OPCO, LLC	95%	None				
Lockwood AH Partners	5%	Transitional Care of Arlington Heights	Arlington Heights			

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	17	Owner Salary - Allocated	$	Transitional Care Management, LLC		$ 16,283	$ 16,283	1
2	V	19	Professional Fees		Transitional Care Management, LLC		4,091	4,091	2
3	V	20	Dues, Subscriptions		Transitional Care Management, LLC		2,928	2,928	3
4	V	21	A&G Salary - Non Owner		Transitional Care Management, LLC		725,780	725,780	4
5	V	21	A&G		Transitional Care Management, LLC		63,280	63,280	5
6	V	24	Seminar		Transitional Care Management, LLC		11,781	11,781	6
7	V	25	Admin. Staff Travel		Transitional Care Management, LLC		47,740	47,740	7
8	V	26	Insurance		Transitional Care Management, LLC		15,195	15,195	8
9	V	27	Employee Benefits		Transitional Care Management, LLC		183,206	183,206	9
10	V	30	Depreciation		Transitional Care Management, LLC		331	331	10
11	V	34	Building Rent		Transitional Care Management, LLC		14,789	14,789	11
12	V				Transitional Care Management, LLC				12
13	V	17	Management Fees	523,415	Transitional Care Management, LLC			(523,415)	13
14	Total			$ 523,415			$ 1,085,404	$ * 561,989	14

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Brian Cloch	Administrative	Administrative	8.5%	0	0	0.00	Allocated	$ 16,283	17-7	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	$ 16,283		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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

Name of Related Organization: Transitional Care Management, LLC
Street Address: 3333 Warrenville Rd. Suite 200
City / State / Zip Code: Lisle, IL 60532
Phone Number: (847) 720-8751
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	17	Owner Salary - Allocated	Patient Days	65,100		$ 21,120	$ 21,120	50,191	$ 16,283	1
2	19	Professional Fees	Patient Days	65,100		5,306		50,191	4,091	2
3	20	Dues, Subscriptions	Patient Days	65,100		3,798		50,191	2,928	3
4	21	A&G Salary - Non Owner	Patient Days	65,100		941,369	941,369	50,191	725,780	4
5	21	A&G	Patient Days	65,100		82,077		50,191	63,280	5
6	24	Seminar	Patient Days	65,100		15,281		50,191	11,781	6
7	25	Admin. Staff Travel	Patient Days	65,100		61,921		50,191	47,740	7
8	26	Insurance	Patient Days	65,100		19,709		50,191	15,195	8
9	27	Employee Benefits	Patient Days	65,100		237,627		50,191	183,206	9
10	30	Depreciation	Patient Days	65,100		429		50,191	331	10
11	34	Building Rent	Patient Days	65,100		19,182		50,191	14,789	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					$ 1,407,819	$ 962,489		$ 1,085,404	25

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Lake County		X	Working Capital			2,013,111	1,131,111				6
7	Due to Partners	X		Working Capital			99,337	99,337				7
8												8
9	TOTAL Facility Related						$ 2,112,448	$ 1,230,448			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,112,448	$ 1,230,448			$	15

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

*** 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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

Facility pays real estate tax as part of rent

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winchester House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0054049

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 189,077 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 16,144 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 1,117 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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Lights - Entire Facility			2015	9,380		20	469	469	547	9
10	Lights - Entire Facility			2015	3,225		20	161	161	215	10
11	Lights - Entire Facility			2015	3,225		20	161	161	202	11
12	B-Wing Improvements			2015	4,550		20	228	228	265	12
13	1st Floor patient room Floor, Walls			2015	8,096		20	405	405	439	13
14	Lights - Entire Facility			2016	3,060		20	140	140	140	14
15	Painting 1st floor patient Room			2016	2,225		20	102	102	102	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	Book Depreciation					9,741					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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 33,761	$ 9,741		$ 1,666	$ 1,666	$ 1,910	70

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 8,256	$	$ 1,651	$ 1,651	5	$ 1,922	71
72	Current Year Purchases	13,260		1,426	1,426	5	1,425	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 21,516	$	$ 3,077	$ 3,077		$ 3,347	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 55,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,741	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 4,743	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,998)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,257	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	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.

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Lake County

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 [X] 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:		224		$ 316,000			3
4	Additions							4
5								5
6								6
7	TOTAL		224		$ 316,000 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 6,659 Description: Copy Machine
(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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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
   - [X] 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	39-1	hrs	$ 241,053		$	$		$ 241,053	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	55,101					55,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	323,006					323,006	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				116,776		116,776	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2/Therapy Supplies	39-02					52,728		52,728	12
13	Other (specify): Lab/X-Ray/Equipment	39-03				54,853			54,853	13
14	TOTAL			$ 619,160		$ 54,853	$ 169,504		$ 843,517	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 **#** 0054049 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 549,483	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 159,479)	1,507,977		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	58,276		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,115,736	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	24,381		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	30,896		16
17	Accumulated Depreciation (book methods)	(10,987)		17
18	Deferred Charges	46,450		18
19	Organization & Pre-Operating Costs	16,144		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,704)		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)**	$ 105,180	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,220,916	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 639,515	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,329		28
29	Short-Term Notes Payable	99,337		29
30	Accrued Salaries Payable	353,863		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Garnishments	700		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,192,744	$	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	Lake County Start Up Capital	1,131,111		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,131,111	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,323,855	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (102,940)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,220,915	$	48

***(See instructions.)**

Facility Name & ID Number Winchester House **#** 0054049 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (505,935)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (505,935)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	402,995	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)**	$ 402,995	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)**	$ (102,940)	24 *

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 22,570,108	1
2	Discounts and Allowances for all Levels	(14,331,847)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,238,261	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,814,972	6
7	Oxygen	25,610	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,840,582	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,620	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,480	19
20	Radiology and X-Ray	2,325	20
21	Other Medical Services	56,060	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 330,485	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,167	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,167	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lake County Progress Payments	1,753,757	28
28a	Lake County Debt Forgiveness	900,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,653,757	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,064,252	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,903,925	31
32	Health Care	4,877,769	32
33	General Administration	4,293,377	33
	B. Capital Expense		
34	Ownership	333,517	34
	C. Ancillary Expense		
35	Special Cost Centers	843,528	35
36	Provider Participation Fee	409,141	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,661,257	40
41	**Income before Income Taxes (line 30 minus line 40)****	402,995	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 402,995	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,126,214	44
45	Private Pay - Net Inpatient Revenue	1,297,729	45
46	Medicare - Net Inpatient Revenue	27,801	46
47	Other-(specify) Managed Care	3,182,418	47
48	Other-(specify) Hospice	604,099	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,238,261	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2,264	2,353	$ 119,243	$ 50.68	1
2	Assistant Director of Nursing	1,170	1,238	50,083	40.45	2
3	Registered Nurses	39,847	40,486	1,442,531	35.63	3
4	Licensed Practical Nurses	16,158	17,410	524,625	30.13	4
5	CNAs & Orderlies	113,717	123,830	1,978,139	15.97	5
6	CNA Trainees					6
7	Licensed Therapist	13,299	14,076	619,171	43.99	7
8	Rehab/Therapy Aides	3,634	4,035	70,732	17.53	8
9	Activity Director	2,804	3,124	60,393	19.33	9
10	Activity Assistants	7,496	8,382	110,980	13.24	10
11	Social Service Workers	3,832	4,194	146,290	34.88	11
12	Dietician	1,005	1,055	32,631	30.93	12
13	Food Service Supervisor	1,975	2,091	47,538	22.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,861	30,837	447,631	14.52	15
16	Dishwashers					16
17	Maintenance Workers	3,180	3,403	90,879	26.70	17
18	Housekeepers	1,853	2,091	54,232	25.93	18
19	Laundry					19
20	Administrator	1,960	2,120	118,081	55.70	20
21	Assistant Administrator	305	305	7,920	25.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,857	16,861	404,324	23.98	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	1,898	2,093	42,267	20.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	260,116	279,985	$ 6,367,690 *	$ 22.74	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	17,600	9-3	36
37	Medical Records Consultant	Monthly	27,637	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,044	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	1,104	11-3	44
45	Social Service Consultant	23	552	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	69	$ 58,937		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Prestel	Administrator	0	$ 11,801
Olivia Christiansen	Ass't. Administrator	0	7,960
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 19,761

B. Administrative - Other

Description	Amount
Management Fee - Transitional Care Management	$ 523,415
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 523,415

C. Professional Services

Vendor/Payee	Type	Amount
DOL Audit	Legal	$ 16,582
Legal Fees	Legal	75,089
FGMK, LLC	Accounting	72,802
Marcum	Healthcare Consulting	82
Paycom	Payroll Processing	79,967
Allison Conulting	Marketing Consulting	26,661
Pinnacle Quality Insight	Customer Svc. Questionnaire	18,160
Stone, McGuire, Segal	Consulting	10,959
Transitional Care Management	HR Consulting	17,348
FGMK, LLC	Consulting	830
Transitional Care Management	AR Consulting	7,335
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 325,815

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 237,520
Unemployment Compensation Insurance	
FICA Taxes	455,261
Employee Health Insurance	1,288,103
Employee Meals	5,820
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Taxes - SUCI	97,002
Payroll Taxes - FUTA	9,952
EE Disability/Life/Dental/Vision Insur	55,962
401k Expense	5,953
Other Employee Benefits	9,068
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,164,641

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	$
Advertising: Employee Recruitment	106,526
Health Care Worker Background Check	5,285
(Indicate # of checks performed)	
Patient Background Checks 63	630
Dues & Subscriptions	3,843
Licenses	2,887
Marketing Costs	8,491
Less: Public Relations Expense	( )
Non-allowable advertising	(8,491)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 119,171

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,898
Seminar Expense	16,490
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,388

* Attach copy of IMRF notifications

**See instructions.

Transitional Care of Lake County
0054049
Page 21-Supplemental
Auto and Travel
1/1/2016-12/31/2016

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	parking/Tolls	RENTAL CAR	AIRFARE	HOTEL	TOTAL	
02/02/16	Beth Benoudiz	Management	DC to Chicago	Meet with Lake County		33.3	92.81	396.2		522.31	
11/25/16	Rhonda Guzman	Activity Director		IOLTA Conference					129.47	129.47	
2016	Terri Galloway	Recruiter	TCLC	Meetings	374.88						
2016	Mark Mullan	Dietary Supervisor	Various local		264.55						
2016	A. Goldberg	Marketing director	Various local	Marketing	882.1						ADJ
2016	L. Hozey	Admissions	Various local	Social worker meetings	460.51						
2016	Olivia Christiansen	Management company	TCLC	Work at building	803.63						
2016	Alvin Pangilinan	Management company	TCLC	Work at building	1207.13						
2016	Heidi Riech-Aguilar	Hospital Liaison	Various local	Hospital visits	2367.59						
2016	Jackie Presel	Administrator	Local seminars	Seminars	153.18						
2016	Rhonda Guzman	Therapy Director	Local visits	Hospital visits	197.8						
2016	Alyssandra MacKaye	Specialty Proj Coord	Local visits	Hospital visits	322.67						
2016	Tiffany Kendzior	Business office	Local seminars	Seminars	30.19						
2016	Various	Various	Local Parking	Various meetings	64						
				Adjustments	-882.1						
					6246.13					651.78	

Transitional Care of Lake County
0054049
Page 21-Supplemental
Legal Schedule
1/1/2016-12/31/2016

DATE	G/L ACCT. #	PAYEE/VENDOR	AMOUNT	
2/1/2016	80550.000	Much Shelist - REVIEW 855 FORMS WITH B CLOCH, JAN 2016	214	ADJ
2/1/2016	80550.000	Polsinelli - SERVICES THRU DEC 15, 2015	2143.5	ADJ
2/29/2016	80550.000	Stone, McGuire & Siegel - LEGAL FEES FOR FEB	467.5	ADJ
2/29/2016	80550.000	Recl Legal fees - Laner Muchin thru 1/11	618.75	ADJ
5/25/2016	80550.000	Laner Muchin, LTD - Phone call with Brian/Mike F AFSCME Invoices	255	ADJ
5/26/2016	80550.000	Laner Muchin, LTD - Review Mike F answers and memo	127.5	ADJ
6/30/2016	80550.000	Stone, McGuire & Siegel - Research and develop materials	517.5	ADJ
6/30/2016	80550.000	Much Shelist - 06/20/2016 Complaint Survey	1712	ADJ
7/31/2016	80550.000	Recl Laner Muchin - Laner, Muchin 498759	382.5	ADJ
7/31/2016	80550.000	Much Shelist - Draft, edits, review IDPH letter	3638	ADJ
8/31/2016	80550.000	Laner Muchin, LTD - Phone Conf regarding CBA	892.5	ADJ
8/31/2016	80550.000	Laner Muchin, LTD - Phone Conferences and Preparation	1020	ADJ
8/31/2016	80550.000	Laner Muchin, LTD - Emails, Prep, calls,etc	2693.75	ADJ
8/31/2016	80550.000	Much Shelist - Services Rendered thru 08/31/2016	321	ADJ
8/31/2016	80550.000	Much Shelist - Services Rendered thru 08/31/2016	4169.4	ADJ
8/31/2016	80550.000	Much Shelist - Legal Fees	341	ADJ
8/1/2016	80550.000	Much Shelist - Aug Invoice 451939 short paid by 17.75	17.75	ADJ
9/1/2016	80550.000	Much Shelist - SEPTEMBER INVOICE 453360 OVERPAY BY $20	-20	ADJ
8/1/2016	80550.000	Much Shelist - Missed invoice from AUG	21.07	ADJ
10/31/2016	80550.000	Recl Professional fees - Laner Muchin 505762	255	ADJ
10/31/2016	80550.000	Recl Professional fees - Laner Muchin 504574	2083.19	ADJ
10/31/2016	80550.000	Laner Muchin, LTD - Drafting,Travel OCt	384.52	ADJ
10/31/2016	80550.000	Laner Muchin, LTD - Emails Sept	618.75	ADJ
10/31/2016	80550.000	Much Shelist - Services through 10/31/16	235.5	ADJ
10/31/2016	80550.000	Much Shelist - OCt 2016 License/Cert Survey	6152.5	ADJ
9/1/2016	80550.000	Laner Muchin, LTD - Over paid invoice 501870	-382.5	ADJ
11/30/2016	80550.000	Laner Muchin, LTD - Legal Fees November2016	7650	ADJ
11/30/2016	80550.000	Laner Muchin, LTD - Legal fees 10/21/16	255	ADJ
11/30/2016	80550.000	Stone, McGuire & Siegel - Legal Servies thru nov 30 2016	1467.5	ADJ
11/22/2016	80550.000	Much Shelist - Phone call 11/22/16 Denise/Jackie	160.5	ADJ
11/30/2016	80550.000	Much Shelist - Services thru 11/30/2016	12444	ADJ
12/31/2016	80550.000	Much Shelist - DUPLICATE PAYMENT - 4442828; OVERPAYMENT - MUCHSHEL	-214.07	ADJ
2/29/2016	80550.000	Recl Legal fees - Laner Muchin thru 1/20	3473.94	
2/29/2016	80550.000	Recl Legal fees - Stone, McGuire 1/31	835	
2/29/2016	80550.000	Recl Legal fees - Laner Muchin thru 2/16	495	
3/1/2016	80550.000	Much Shelist - Legal Fees	321	
3/1/2016	80550.000	Much Shelist - Legal Fees	214	
3/1/2016	80550.000	Much Shelist - Legal Fees	267.57	
4/1/2016	80550.000	Much Shelist - Legal Fees	963	
4/30/2016	80550.000	Recl prof fees - Williams & Baerson 25081	503.75	
4/30/2016	80550.000	Recl prof fees - Williams & Baerson 25080	503.75	
4/30/2016	80550.000	Recl prof fees - Laner Muchin 4896578	2621.47	
4/30/2016	80550.000	Recl prof fees - Laner Muchin 489159	840	
5/31/2016	80550.000	Stone, McGuire & Siegel - Research compiance law, reports and data	395	
5/1/2016	80550.000	Laner Muchin, LTD - Phone Conference With Mike F and Colin T	382.5	
5/20/2016	80550.000	Laner Muchin, LTD - Phone Conferences and review	2040	
5/1/2016	80550.000	Laner Muchin, LTD - Phone Conferences and reviewing of files	958.75	
5/20/2016	80550.000	Laner Muchin, LTD - Conference, drafting, and review	3065	
5/31/2016	80550.000	Recl professional fees - Laner Muchin	6566.25	
		Adjustments	-50643	
		TOTAL:	24445.5	

Transitional Care of Lake County
0054049
Page 21-Supplemental
Seminar Schedule
1/1/2016-12/31/2016

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
01/18/16	Creative Rehab Strategies LLC	In Service Employee Educ - CPE	Various	Various	TCLC	1,579.06
01/26/16	TCLC	Dementia Training	Rhonda Guzman	Directory of Therapy	WEB	53.60
01/31/16	Petty Cash	Training	4th Floor emp	RN, LPN, CAN	Libertyville, IL	64.90
02/05/16	TCLC	Lymphederma and ICD10	J Prestel	Administrator	WEB	397.99
02/05/16	TCLC	OSH Seminar	S Wolfe	HR	WEB	45.60
02/19/16	TCLC	Lymphederma	J Hendershot	OT	WEB	107.75
02/19/16	TCLC	Wound Seminar	E Ramos & L Gregorio	DON/LPN	WEB	120.00
02/24/16		PBJ Webinar	Sarah Glumm	Clinical Officer	Libertyville, IL	75.00
02/29/16	Continuing Educ Institute of IL	Living with Lymphedema			WEB	315.00
02/29/16	TCLC Payroll	ICD 10 Training			WEB	41.82
03/01/16	Creative Rehab Strategies LLC	In Service Employee Educ - CPE	Various	Various	TCLC	2,992.05
03/18/16	TCLC	AOTA Conference	R Guzman	Directory of Therapy	Naperville, IL	661.00
03/31/16	Olivia Christiansen	NFPA			WEB	1,740.00
03/31/16		Pathway Education	Sarah Glumm	Clinical Officer	WEB	95.34
04/08/16	TCLC	Practice Guidelines for Dementia	Rhonda	Directory of Therapy	WEB	74.09
05/10/16	Proactive Medical Review & Consulting	Rehab Documentation	Rhonda	Directory of Therapy	Libertyville, IL	508.75
05/25/16	Olivia Christiansen	IHCA Conference	Tammy H	DON	Springfield, IL	95.00
06/30/16	Olivia Christiansen	Lorman Education Services	Jackie Prestel	Administrator	Milwaukee, WI	524.00
07/08/16	TCLC	Humana Conference/Medicare	T Kendzior	Business Office	Milwaukee, WI	150.96
07/21/16	CPI	Dementia Capable Care	Alyssandra	Unit Manager	Libertyville, IL	259.00
08/31/16	TCLC	Medicare Training	Tiffany	Business Office	Orland Park, IL	55.00
08/31/16	Transitional Care Management	Food Handlers Permit	Olivia	Dietary	WEB	49.50
09/01/16	ILOTA	ILOTA Conference	R Guzman	Directroy of Activites	Naperville, IL	351.00
09/15/16	CPI	Dementia Capable Care	Alyssandra, Rhonda	Unit Manager, Dir of Activities	Libertyville, IL	702.29
09/23/16	Continuing Educ Institute of IL	Strategies in Dementia	Alyssandra	Unit Manager	Rockford, IL	357.00
09/28/16	Illinois Healthcare Assoc	Understanding Quality	Alyssandra, Sarah	Unit Manager, Clinical Officer	Palatine, IL	90.00
09/30/16	TCLC	Dementia CEU	Rhonda, Alyssandra, Jackie	DOA, Unit Manger, Administrator	Park Ridge, IL	60.00
10/04/16	CE Solutions	CE Solutions			WEB	4,382.81
11/21/16	CEUS	CEUS	Sarah Glumm	Clinical Officer	WEB	105.00
11/25/16	TCLC	IOLTA Conference	D Kayler	Directory of Therapy	Naperville, IL	336.00
11/25/16	TCLC	ACMA Conference	H Agular	Director of Bus Dev	Rosemont, IL	100.00
						16,489.51

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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? **No**
If YES, give association name and amount. **N/A**

(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? **NA**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **409,141**
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. $ **No** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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? **Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees