FOR BHF USE

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

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: 0052100

Facility Name: Winfield Woods Hlthcare Ctr

Address: 28W141 Liberty St (Number) Winfield (City) 60190 (Zip Code)

County: Dupage

Telephone Number: (630) 668-9696 **Fax #** (630) 668-7078

HFS ID Number:

Date of Initial License for Current Owners: 41211

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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	31	Skilled (SNF)	31	11,346	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,508	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			4,342	4,342	8
9	SNF/PED					9
10	ICF	40,669	2,401		43,070	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,669	2,401	4,342	47,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.87%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/29/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/29/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 4,254

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	219,807	7,633	13,390	240,830		240,830		240,830			1
2	Food Purchase		339,000		339,000		339,000	(1,100)	337,900			2
3	Housekeeping	173,432	44,412	54	217,898		217,898		217,898			3
4	Laundry	66,324	3,410		69,734		69,734		69,734			4
5	Heat and Other Utilities			209,115	209,115		209,115	507	209,622			5
6	Maintenance	41,528		68,497	110,025		110,025	324	110,349			6
7	Other (specify):* Waste Removal			13,301	13,301		13,301		13,301			7
8	TOTAL General Services	501,091	394,455	304,357	1,199,903		1,199,903	(269)	1,199,634			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,685,522	152,364	26,017	1,863,903		1,863,903	74,376	1,938,279			10
10a	Therapy	105,840	1,370	23,904	131,114		131,114	(2,352)	128,762			10a
11	Activities	99,452		114	99,566		99,566		99,566			11
12	Social Services	151,825		42,500	194,325		194,325		194,325			12
13	CNA Training											13
14	Program Transportation			487	487		487		487			14
15	Other (specify):*							13,160	13,160			15
16	TOTAL Health Care and Programs	2,042,639	153,734	108,022	2,304,395		2,304,395	85,184	2,389,579			16
	C. General Administration											
17	Administrative	143,698		443,813	587,511		587,511	(350,498)	237,013			17
18	Directors Fees											18
19	Professional Services			136,407	136,407		136,407	8,548	144,955			19
20	Dues, Fees, Subscriptions & Promotions			34,918	34,918		34,918	(1,147)	33,771			20
21	Clerical & General Office Expenses	168,522	25,539	76,979	271,040		271,040	117,445	388,485			21
22	Employee Benefits & Payroll Taxes			427,407	427,407		427,407		427,407			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,378	2,378		2,378	594	2,972			24
25	Other Admin. Staff Transportation			12,534	12,534		12,534	1,808	14,342			25
26	Insurance-Prop.Liab.Malpractice			86,097	86,097		86,097	1,447	87,544			26
27	Other (specify):*							32,752	32,752			27
28	TOTAL General Administration	312,220	25,539	1,220,533	1,558,292		1,558,292	(189,051)	1,369,241			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,855,950	573,728	1,632,912	5,062,590		5,062,590	(104,136)	4,958,454			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Winfield Woods Hlthcare Ctr #0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			86,668	86,668		86,668	145,051	231,719			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,700	78,700		78,700	855,179	933,879			32
33	Real Estate Taxes			73,503	73,503		73,503	(1,146)	72,357			33
34	Rent-Facility & Grounds			777,980	777,980		777,980	(760,224)	17,756			34
35	Rent-Equipment & Vehicles			46,320	46,320		46,320		46,320			35
36	Other (specify):*											36
37	TOTAL Ownership			1,063,171	1,063,171		1,063,171	238,860	1,302,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,430	613,330	764,760		764,760	(93,835)	670,925			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			337,852	337,852		337,852		337,852			42
43	Other (specify):* Nonallowable Exp		941	260,540	261,481		261,481	(261,481)				43
44	TOTAL Special Cost Centers		152,371	1,211,722	1,364,093		1,364,093	(355,316)	1,008,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,855,950	726,099	3,907,805	7,489,854		7,489,854	(220,592)	7,269,262			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(2,821)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	145,051	30		9
10	Interest and Other Investment Income	(192)	32		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	(3,780)	43		18
19	Entertainment				19
20	Contributions	(23,425)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,210)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,500)	43		24
25	Fund Raising, Advertising and Promotional				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 See Page 5A	(18,664)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,541)		$	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)	(109,051)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (109,051)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,592)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Winfield Woods Hlthcare Ctr

ID# 0052100

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (1,100)	2	1
2	Marketing Expense	(13,955)	43	2
3	Additional R&M	2,671	6	3
4	Disallow RE Tax late fee	(1,146)	33	4
5	PAC Dues	(2,605)	20	5
6	Capitalize Repairs & Maint	(2,529)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	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	507	0	0	0	0	0	0	0	0	507	5
6	Maintenance	142	0	182	0	0	0	0	0	0	0	0	324	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(958)	0	689	0	0	0	0	0	0	0	0	(269)	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	80,479	(6,103)	0	0	0	0	0	0	0	74,376	10
10a	Therapy	0	0	0	0	(2,352)	0	0	0	0	0	0	(2,352)	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	13,160	0	0	0	0	0	0	0	0	13,160	15
16	TOTAL Health Care and Programs	0	0	93,639	(6,103)	(2,352)	0	0	0	0	0	0	85,184	16
	C. General Administration													
17	Administrative	0	0	(350,498)	0	0	0	0	0	0	0	0	(350,498)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,210)	0	9,898	0	3,860	0	0	0	0	0	0	8,548	19
20	Fees, Subscriptions & Promotions	(2,605)	0	1,231	0	227	0	0	0	0	0	0	(1,147)	20
21	Clerical & General Office Expenses	0	0	116,436	0	1,009	0	0	0	0	0	0	117,445	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	594	0	0	0	0	0	0	0	0	594	24
25	Other Admin. Staff Transportation	0	0	864	0	944	0	0	0	0	0	0	1,808	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	1,447	0	0	0	0	0	0	1,447	26
27	Other (specify):*	0	0	32,752	0	0	0	0	0	0	0	0	32,752	27
28	TOTAL General Administration	(7,815)	0	(188,723)	0	7,487	0	0	0	0	0	0	(189,051)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,773)	0	(94,395)	(6,103)	5,135	0	0	0	0	0	0	(104,136)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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	145,051	0	0	0	0	0	0	0	0	0	0	145,051	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(192)	850,934	0	0	4,437	0	0	0	0	0	0	855,179	32
33	Real Estate Taxes	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	33
34	Rent-Facility & Grounds	0	(777,980)	17,756	0	0	0	0	0	0	0	0	(760,224)	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**	143,713	72,954	17,756	0	4,437	0	0	0	0	0	0	238,860	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	(93,835)	0	0	0	0	0	0	(93,835)	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):*	(246,481)	0	(15,000)	0	0	0	0	0	0	0	0	(261,481)	43
44	**TOTAL Special Cost Centers**	(246,481)	0	(15,000)	0	(93,835)	0	0	0	0	0	0	(355,316)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,541)	72,954	(91,639)	(6,103)	(84,263)	0	0	0	0	0	0	(220,592)	45

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	32	Interest		Winfield Woods Realty	100.00%	$ 567,256	$ 567,256	1
2	V	32	Amortiztion of loan costs		Winfield Woods Realty	100.00%	283,678	283,678	2
3	V	34	Rent-Facility & Grounds	777,980	Winfield Woods Realty	100.00%		(777,980)	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			$ 777,980			$ 850,934	$ * 72,954	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 507	$ 507	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	182	182	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	80,479	80,479	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	13,160	13,160	18
19	V	17	Administrative	443,813	Premier Healthcare Management, LLC	100.00%	93,315	(350,498)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	9,898	9,898	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	1,231	1,231	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	116,436	116,436	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	594	594	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	864	864	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	32,752	32,752	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	17,756	17,756	26
27	V	43	Marketing Consultant	15,000	Premier Healthcare Management, LLC	100.00%		(15,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 458,813			$ 367,174	$ * (91,639)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 9,623	Premier Healthcare Supplies, LLC	100.00%	$ 3,520	$ (6,103)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,623			$ 3,520	$ * (6,103)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	$ 2,352	REX Therapeutics	100.00%	$	$ (2,352)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	3,860	3,860	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	227	227	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	1,009	1,009	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	944	944	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	1,447	1,447	20
21	V	32	Interest Expense		REX Therapeutics	100.00%	4,437	4,437	21
22	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	48,301	48,301	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	3,217	3,217	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	18,097	18,097	24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	371,855	371,855	27
28	V	39	Contract Therapy	535,305	REX Therapeutics	100.00%		(535,305)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 537,657			$ 453,394	$ * (84,263)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Joseph Knopf	2.8990%	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	2.8990%	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Naomi Lopin	2.8990%	Champaign Urbana Nursing and Rehab	Champaign	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lopin	2.8990%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Michael & Carol Knopf	1.4490%	Gardenview Manor	Danville	Winfield Woods	Winfield	Lessor	5
6	Isaac & Rachel Knopf	0.7250%	Norridge Gardens	Norridge	Realty			6
7	BDS Whampoa LLC	2.1740%	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN	REX Therapeutics	Skokie	Therapy	7
8	Orsheve Enterprises	5.0720%	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	Shalom Zupnik	1.4490%	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10	Jerry & Deena Cheplowitz	0.7250%	Premier Healthcare of Connersville, LLC	Connersville, IN				10
11	Felice Frand	0.7250%						11
12	Roslyn Indich	0.7250%						12
13	Barak Baver	37.6810%						13
14	David Cheplowitz	37.6810%						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	David Cheplowitz	Shareholder	Administrative	37.68%	See Att Sch 7A	5.43	14%	Alloc Salary	$ 21,196	17-7	1
2	Barak Baver	Shareholder	Administrative	37.68%	See Att Sch 7A	5.43	14%	Alloc Salary	21,196	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	5.43	14%	Alloc Salary	6,005	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 48,397		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	5	Heat and Other Utilities	Census Days	348,950	11	$ 3,732	$	47,412	$ 507	1
2	6	Maintenance	Census Days	348,950	11	1,338		47,412	182	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	47,412	80,479	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		47,412	13,160	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	47,412	93,315	5
6	19	Professional Services	Census Days	348,950	11	72,849		47,412	9,898	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		47,412	1,231	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	47,412	116,436	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		47,412	594	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		47,412	864	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		47,412	32,752	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		47,412	17,756	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					$ 2,702,363	$ 2,066,407		$ 367,174	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: Premier Healthcare Supplies, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	10	Nursing and Medical Records	Revenue	111,222	11	$ 40,679	$	9,623	$ 3,520	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					$ 40,679	$		$ 3,520	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	19	Professional Services	Therapy Revenue	3,342,403	4	$ 23,994	$	537,657	$ 3,860	1
2	20	Fees and Subscriptions	Therapy Revenue	3,342,403	4	1,410		537,657	227	2
3	21	Clerical & General Office Exp	Therapy Revenue	3,342,403	4	6,268		537,657	1,009	3
4	25	Other Admin Staff Transp	Therapy Revenue	3,342,403	4	5,868		537,657	944	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	3,342,403	4	8,993		537,657	1,447	5
6	32	Interest Expense	Therapy Revenue	3,342,403	4	27,581		537,657	4,437	6
7	39	Allocated Employee Benefits	Therapy Revenue	3,342,403	4	300,276		537,657	48,301	7
8	39	Therapy Consultant	Therapy Revenue	3,342,403	4	20,000		537,657	3,217	8
9	39	Therapy Management Wages	Therapy Revenue	3,342,403	4	112,504	112,504	537,657	18,097	9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	371,855	1	371,855	371,855	371,855	371,855	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					$ 878,749	$ 484,359		$ 453,394	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$			$ 183,757	1
2	Bank Leumi		X	Mortgage	$21,720.00	5/31/2016	12,480,000	12,349,680	5/31/2021	0.0350	299,129	2
3	Bank Leumi		X	Mortgage	$6,130.00	5/31/2016	3,520,000	3,483,220	5/31/2021	0.0350	84,370	3
4												4
5												5
	Working Capital											
6	MB Financial		X	Note Payable							19,447	6
7	Bank Leumi		X	Line of Credit				1,148,434			16,443	7
8												8
9	TOTAL Facility Related				$27,850.00		$ 16,000,000	$ 16,981,334			$ 603,146	9
	B. Non-Facility Related*											
10								Allocated from REX Therapeutics			4,437	10
11								Amortization of loan costs			326,488	11
12								Offset Interest Income			(192)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 330,733	14
15	TOTALS (line 9+line14)						$ 16,000,000	$ 16,981,334			$ 933,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)**

SEE ACCOUNTANTS' PREPARATION REPORT

**** 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 Winfield Woods Hlthcare Ctr **#** 0052100 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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.**		$ 92,411	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.)	2015	$ 76,432	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,979)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 88,336	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.		$ 72,357	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	72,663	9
2013	73,455	10
2014	74,020	11
2015	76,432	12

Accrual based on prior year tax bill.

Note: Beg accrual adjusted to reflect adj beg balance

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winfield Woods Hlthcare Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0052100

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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.	04-14-201-003	Long Term Care Property	$ 76,431.78	$ 76,431.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,431.78	$ 76,431.78

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 X 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 Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,991 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 2

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2015	$ 460,000	1
2					2
3	TOTALS			$ 460,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	138		2015	1971	$ 4,400,000	$	35	$ 125,714	$ 125,714	$ 251,428	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rci Delayed Egress Mag Lock With Internal Sounder			2013	3,716		20	743	743	2,911	9
10	5 New Wall Outlets: 3 On Second Floor, 2 On First Floor			2013	2,800		20	140	140	478	10
11	Electric Installation Of Emergency Outlets			2013	30,100		20	772	772	2,862	11
12	Landscaping			2014	3,400		20	97	97	267	12
13	Elevator Door Repair			2014	3,750		20	107	107	286	13
14	Rooftop Replacement			2014	11,268		20	322	322	805	14
15	Replace Water Heater/Pipes/Valves For Kitchen/Laundry Room			2015	7,749		20	387	387	774	15
16	Installation Of Electrical Sources/Wiring In Mechanical Room			2015	6,455		20	323	323	646	16
17	Rebuilding Of Chimney/Tuckpointing			2015	8,700		20	435	435	870	17
18	Instal Of New Heat Exchanger/New Burners/Rollout Switch			2015	7,438		20	372	372	744	18
19	Wanderguard Id/Wall Mounts/Signaling Device/Magnetic Locks			2015	29,745		20	1,487	1,487	2,974	19
20	Install Roam Alert System/Door Controller/Electrical			2015	31,619		20	1,581	1,581	3,162	20
21	Install Roam Alert Eco Door Control/Excitor Antenna/Annunciator			2015	21,705		20	1,085	1,085	2,170	21
22	Generator			2015	3,136		20	314	314	628	22
23	Generator			2015	3,136		20	314	314	628	23
24	Installed New Motor, Housing and Backplate at RTU #1			2016	2,529		20	63	63	63	24
25	Installed 16 New Smoke/Fire Damper Motors			2016	8,221		20	206	206	206	25
26	Clean, Patch, Seal and Stripe Parking Lot			2016	5,700		20	143	143	143	26
27	Re-pipe Generator Feed			2016	3,428		20	86	86	86	27
28	Parking Lot Repaving			2016	5,352		20	134	134	134	28
29	Install 9 Door Alarms and Nursing Station Annunciators			2016	6,295		20	157	157	157	29
30	Install Emergency Call System			2016	18,600		20	465	465	465	30
31	Elevator Repairs-Replaced Micro-chip, Adjust Rollers, Rebuilt Starter			2016	3,157		20	79	79	79	31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Allocated from Premier Healthcare Management, LLC	2013	3,383		20	169	169	540	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)		$ 4,631,382	$		$ 135,695	$ 135,695	$ 273,506	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 950,455	$	$ 95,046	$ 95,046	10	$ 237,611	71
72	Current Year Purchases	19,569		978	978	10	978	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 970,024	$	$ 96,024	$ 96,024		$ 238,589	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)	$ 6,061,406	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)	$ 231,719	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 231,719	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 512,095	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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	Allocated from Management Co.				17,756			5
6								6
7	TOTAL				$ 17,756 **			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: $ 27,019 Description: Medical Equipment
(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	Facility	Lexus	1,608	19,301	18
19					19
20					20
21	TOTAL		$ 1,608	$ 19,301	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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), 39(3)	2927 hrs	$ 119,620		$ 25,099	$	2,927	$ 144,719	1
2	Licensed Speech and Language Development Therapist	39(1), 39(3)	1136 hrs	46,418		9,740		1,136	56,158	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(1), 39(3)	5036 hrs	205,817		43,186		5,036	249,003	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				151,040		151,040	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Rehab Supplies	10A(2)					1,370		1,370	12
13	Other (specify): See Attached Schedule 16A		233	18,097		51,518	390	233	70,005	13
14	TOTAL			$ 389,952		$ 129,543	$ 152,800	9,332	$ 672,295	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Winfield Woods Hlthcare Ctr**
IDPH License ID Number: **0052100**
Fiscal Year End: **12/31/16**

Schedule 16A

XIV. Special Services

Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Medical Supplies - MCA	39(2)	390
Therapy Consultant	39(3)	3,217
Employee Benefits Allocated from REX	39(3)	48,301
Therapy Manager	39(1)	18,097
Total - Line 13		**70,005**

Facility Name & ID Number Winfield Woods Hlthcare Ctr **#** 0052100 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 17,481	$ 17,525	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 403,041)	1,408,760	1,408,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,829	25,829	6
7	Other Prepaid Expenses	5,030	5,030	7
8	Accounts Receivable (owners or related parties)	1,940,533	6,116,128	8
9	Other(specify): Due from prior owner	23,105	23,105	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,420,738	$ 7,596,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		460,000	13
14	Buildings, at Historical Cost		4,400,000	14
15	Leasehold Improvements, at Historical Cost	200,051	231,382	15
16	Equipment, at Historical Cost	298,478	970,024	16
17	Accumulated Depreciation (book methods)	(161,718)	(512,095)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	18,876	18,876	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,400)	(2,400)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	254	2,152,624	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 353,541	$ 7,718,411	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,774,279	$ 15,314,788	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,329,187	$ 1,329,187	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,148,434	4,631,654	29
30	Accrued Salaries Payable	148,894	148,894	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,897	6,897	31
32	Accrued Real Estate Taxes(Sch.IX-B)		88,336	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	18,220	18,220	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,651,632	$ 6,223,188	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,349,680	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)**	$	$ 12,349,680	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,651,632	$ 18,572,868	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,122,647	$ (3,258,080)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,774,279	$ 15,314,788	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Winfield Woods Hlthcare Ctr**
IDPH License ID Number: **0052100**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	(1,421)	200,949
Intangibles		1,950,000
Construction in Progress	1,675	1,675
Total - Line 23	**254**	**2,152,624**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,159,371	1
2	Restatements (describe): Bad Debt Expense		2
3	**Equity Restatement**	(2,157,259)	3
4	**Rounding**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,112	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,388,010	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,017,500	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(4,284,975)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,120,535	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)**	$ 1,122,647	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 7,809,383	1
2	Discounts and Allowances for all Levels	783,168	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,592,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,021	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 284,021	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	192	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 192	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,100	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,100	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,877,864	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,199,903	31
32	Health Care	2,304,395	32
33	General Administration	1,558,292	33
	B. Capital Expense		
34	Ownership	1,063,171	34
	C. Ancillary Expense		
35	Special Cost Centers	1,026,241	35
36	Provider Participation Fee	337,852	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,489,854	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,388,010	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,388,010	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,752,405	44
45	Private Pay - Net Inpatient Revenue	426,986	45
46	Medicare - Net Inpatient Revenue	2,401,230	46
47	Other-(specify) Insurance	11,930	47
48	Other-(specify) Veterans		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,592,551	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,776	2,000	$ 117,605	$ 58.80	1
2	Assistant Director of Nursing	528	528	19,545	37.02	2
3	Registered Nurses	7,757	8,365	254,221	30.39	3
4	Licensed Practical Nurses	20,470	21,346	587,434	27.52	4
5	CNAs & Orderlies	41,946	45,139	591,894	13.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,551	5,283	105,840	20.03	8
9	Activity Director	1,855	1,903	38,771	20.37	9
10	Activity Assistants	3,844	4,424	60,681	13.72	10
11	Social Service Workers	8,894	9,270	151,825	16.38	11
12	Dietician					12
13	Food Service Supervisor	1,758	1,902	37,881	19.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,775	16,666	181,926	10.92	15
16	Dishwashers					16
17	Maintenance Workers	2,249	2,457	41,528	16.90	17
18	Housekeepers	16,651	18,672	173,432	9.29	18
19	Laundry	6,076	6,948	66,324	9.55	19
20	Administrator	2,168	2,272	143,698	63.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,168	9,052	168,522	18.62	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	1,591	1,719	29,159	16.96	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	2,084	2,220	85,664	38.59	33
34	TOTAL (lines 1 - 33)	147,141	160,166	$ 2,855,950 *	$ 17.83	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	Monthly	$ 13,390	L1, C3	35
36	Medical Director	Monthly	15,000	L9, C3	36
37	Medical Records Consultant	27	1,785	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	24,232	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	42,500	L12, C3	45
46	Other(specify)				46
47	Rehab Consultant	Monthly	21,365	L10a, C3	47
48					48
49	TOTAL (lines 35 - 48)	27	$ 118,272		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nora O'Gorman	Administrator	0	$ 134,814
Brian Gallagher	Asst Admin	0	8,884
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,698

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 443,813
TOTAL (agree to Schedule V, line 17, col. 3)	$ 443,813
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 20,573
FR&R/Marcum LLP	Accounting	8,340
Richard Peelo & Associates, Inc.	Accounting	4,200
Sharon Lofgren	Medicare Billing	3,600
Personnel Planners	Unemployment Consulting	1,823
Singer Networks L.L.C.	Data Processing	7,329
HDSI	Data Processing	4,519
ADP	Payroll Processing	19,170
E-Solutions	Data Processing	2,959
Ability Network Inc	Data Processing	5,523
See Attached Schedule 21A		58,371
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 136,407

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,873
Unemployment Compensation Insurance	60,708
FICA Taxes	212,179
Employee Health Insurance	103,146
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,318
Employee Physicals	3,183
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,407

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	18,788
Health Care Worker Background Check	
(Indicate # of checks performed 10)	304
Patient Background Checks 74	2,228
Dues & Subscriptions	1,325
Licenses & Permits	400
IL Council on LTC	5,288
Allocated from Premier Mgmt & REX Ther.	1,458
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,771

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,378
Allocated from Management Co.	594
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,972

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Winfield Woods Hlthcare Ctr**
IDPH License ID Number: **0052100**
Fiscal Year End: **12/31/16**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Terrill Consulting Services, Inc.	Billing Consultant	22,375
IIT/Sorcetech	Computer Services	10
Change Healthcare	Data Processing	679
Matrixcare	Data Processing	35,307
Total		**58,371**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **5,288 IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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. $ **3,920** Line **10**

(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. $ **337,852**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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. $ **N/A**

(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