FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 0054049

Facility Name: Winchester House

Address: 1125 N. Milwaukee Avenue (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 1/1/2017 to 12/31/2017 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, Healthcare
(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: 1/1/2017 Ending: 12/31/2017

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	30,392	5,511	9,045	44,948	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,392	5,511	9,045	44,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.98%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2,654

Medicare Intermediary Wisconsin Physicians 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: 1/1/2017 Ending: 12/31/2017

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	483,253	22,968		506,221		506,221		506,221			1
2	Food Purchase		301,432		301,432		301,432		301,432			2
3	Housekeeping	53,742	26,552	330,432	410,726		410,726		410,726			3
4	Laundry		12,948	154,704	167,652		167,652		167,652			4
5	Heat and Other Utilities			23,266	23,266		23,266		23,266			5
6	Maintenance	66,964		33,593	100,557		100,557		100,557			6
7	Other (specify):*											7
8	TOTAL General Services	603,959	363,900	541,995	1,509,854		1,509,854		1,509,854			8
	B. Health Care and Programs											
9	Medical Director			17,800	17,800		17,800		17,800			9
10	Nursing and Medical Records	3,711,704	242,208	33,780	3,987,692		3,987,692		3,987,692			10
10a	Therapy	60,080		830	60,910		60,910		60,910			10a
11	Activities	223,014	1,582	828	225,424		225,424		225,424			11
12	Social Services	138,621		1,219	139,840		139,840		139,840			12
13	CNA Training											13
14	Program Transportation			5,892	5,892		5,892		5,892			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,133,419	243,790	60,349	4,437,558		4,437,558		4,437,558			16
	C. General Administration											
17	Administrative	119,996		464,046	584,042		584,042	(447,786)	136,256			17
18	Directors Fees											18
19	Professional Services			212,540	212,540		212,540	(61,339)	151,201			19
20	Dues, Fees, Subscriptions & Promotions			147,868	147,868		147,868	(1,014)	146,854			20
21	Clerical & General Office Expenses	357,365	131,261	170,366	658,992		658,992	422,862	1,081,854			21
22	Employee Benefits & Payroll Taxes			1,579,117	1,579,117		1,579,117		1,579,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			35,403	35,403		35,403	(3,071)	32,332			24
25	Other Admin. Staff Transportation							37,676	37,676			25
26	Insurance-Prop.Liab.Malpractice			147,220	147,220		147,220	12,350	159,570			26
27	Other (specify):*							165,244	165,244			27
28	TOTAL General Administration	477,361	131,261	2,756,560	3,365,182		3,365,182	124,922	3,490,104			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,214,739	738,951	3,358,904	9,312,594		9,312,594	124,922	9,437,516			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: 1/1/2017 Ending: 12/31/2017

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			11,056	11,056		11,056	(4,867)	6,189			30
31	Amortization of Pre-Op. & Org.			12,131	12,131		12,131		12,131			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			13,822	13,822		13,822	11,920	25,742			34
35	Rent-Equipment & Vehicles			7,925	7,925		7,925		7,925			35
36	Other (specify):*											36
37	**TOTAL Ownership**			44,934	44,934		44,934	7,053	51,987			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	473,586	126,587	62,377	662,550		662,550		662,550			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			376,815	376,815		376,815		376,815			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	473,586	126,587	439,192	1,039,365		1,039,365		1,039,365			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,688,325	865,538	3,843,030	10,396,893		10,396,893	131,975	10,528,868			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: 1/1/2017 Ending: 12/31/2017

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	(5,065)	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	(983)	21		19
20	Contributions	(550)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(139,125)	21		24
25	Fund Raising, Advertising and Promotional	(2,673)	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	(109,252)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (257,648)		$	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)	389,623		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 389,623		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 131,975		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: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal Fees	$ (58,112)	19	1
2	Bank Fees	(7,264)	21	2
3	Marketing Consultant	(28,796)	19	3
4	Non-Allowable Travel	(1,846)	24	4
5	Non-Allowable Seminar Expense	(1,953)	24	5
6	Non-Allowable Marketing Travel	(11,281)	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**	(109,252)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House # 0054049 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(447,786)	0	0	0	0	0	0	0	0	0	(447,786)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(86,908)	25,569	0	0	0	0	0	0	0	0	0	(61,339)	19
20	Fees, Subscriptions & Promotions	(2,673)	1,659	0	0	0	0	0	0	0	0	0	(1,014)	20
21	Clerical & General Office Expenses	(147,922)	570,784	0	0	0	0	0	0	0	0	0	422,862	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	(15,080)	12,009	0	0	0	0	0	0	0	0	0	(3,071)	24
25	Other Admin. Staff Transportation	0	37,676	0	0	0	0	0	0	0	0	0	37,676	25
26	Insurance-Prop.Liab.Malpractice	0	12,350	0	0	0	0	0	0	0	0	0	12,350	26
27	Other (specify):*	0	165,244	0	0	0	0	0	0	0	0	0	165,244	27
28	**TOTAL General Administration**	(252,583)	377,505	0	0	0	0	0	0	0	0	0	124,922	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(252,583)	377,505	0	0	0	0	0	0	0	0	0	124,922	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winchester House **#** 0054049 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(5,065)	198	0	0	0	0	0	0	0	0	0	(4,867)	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	11,920	0	0	0	0	0	0	0	0	0	11,920	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**	(5,065)	12,118	0	0	0	0	0	0	0	0	0	7,053	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)**	(257,648)	389,623	0	0	0	0	0	0	0	0	0	131,975	45

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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
IHOP JV OPCO, LLC	95%	None		Transitional Care Management		Management Co.
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		$ 16,260	$ 16,260	1
2	V	19	Professional Fees		Transitional Care Management, LLC		25,569	25,569	2
3	V	20	Dues & Subscriptions		Transitional Care Management, LLC		1,659	1,659	3
4	V	21	A&G Salary -Non-Owners		Transitional Care Management, LLC		517,705	517,705	4
5	V	21	A&G		Transitional Care Management, LLC		53,079	53,079	5
6	V	24	Seminar		Transitional Care Management, LLC		12,009	12,009	6
7	V	25	Admin.Staff Travel		Transitional Care Management, LLC		37,676	37,676	7
8	V	26	Insurance		Transitional Care Management, LLC		12,350	12,350	8
9	V	27	Employee Benefits		Transitional Care Management, LLC		165,244	165,244	9
10	V	30	Depreciation		Transitional Care Management, LLC		198	198	10
11	V	34	Building Rent		Transitional Care Management, LLC		11,920	11,920	11
12	V								12
13	V	17	Management Fees	464,046	Transitional Care Management, LLC			(464,046)	13
14	Total			$ 464,046			$ 853,669	$ * 389,623	14

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	0.09	0	0	0.00	Allocated	$ 16,260	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	$ 16,260		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: 1/1/2017 Ending: 2/31/2017

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	74,277		$ 26,869	$ 26,869	44,948	$ 16,260	1
2	19	Professional Fees	Patient Days	74,277		42,254		44,948	25,569	2
3	20	Dues, Subscriptions	Patient Days	74,277		2,741		44,948	1,659	3
4	21	A&G Salary - Non Owner	Patient Days	74,277		855,513	855,513	44,948	517,705	4
5	21	A&G	Patient Days	74,277		87,715		44,948	53,079	5
6	24	Seminar	Patient Days	74,277		19,845		44,948	12,009	6
7	25	Admin. Staff Travel	Patient Days	74,277		62,259		44,948	37,676	7
8	26	Insurance	Patient Days	74,277		20,408		44,948	12,350	8
9	27	Employee Benefits	Patient Days	74,277		273,066		44,948	165,244	9
10	30	Depreciation	Patient Days	74,277		327		44,948	198	10
11	34	Building Rent	Patient Days	74,277		19,698		44,948	11,920	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					$ 1,410,695	$ 882,382		$ 853,669	25

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	1,663,289				6
7												7
8												8
9	TOTAL Facility Related						$ 2,013,111	$ 1,663,289			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,013,111	$ 1,663,289			$	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:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

Facility Pays Real Estate Tax as part of rent

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 38,254 2. Number of Years Over Which it is Being Amortized: Various

3. Current Period Amortization: 12,131 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: 1/1/2017 Ending: 12/31/2017

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	1,876	20	469	(1,407)	1,016	9
10	Lights - Entire Facility			2015	3,225	645	20	161	(484)	376	10
11	Lights - Entire Facility			2015	3,225	645	20	161	(484)	363	11
12	B-Wing Improvements			2015	4,550	910	20	228	(682)	493	12
13	1st Floor patient room Floor, Walls			2015	8,096	1,619	20	405	(1,214)	843	13
14	Lights - Entire Facility			2016	3,060	612	20	153	(459)	293	14
15	Painting 1st floor patient Room			2016	2,225	445	20	111	(334)	213	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

*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: 1/1/2017 Ending: 12/31/2017

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	$ 6,752		$ 1,688	$ (5,064)	$ 3,597	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: 1/1/2017 Ending: 12/31/2017

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	$ 21,516	$ 4,304	$ 4,303	$ (1)	5	$ 7,651	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 21,516	$ 4,304	$ 4,303	$ (1)		$ 7,651	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)	$ 11,056	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,991	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,065)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,248	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: 1/1/2017 Ending: 12/31/2017

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 ☒ 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		$ 13,822			3
4	Additions							4
5								5
6								6
7	TOTAL		224		$ 13,822 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 7,925 Description: Copier/Fax 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					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: 1/1/2017 Ending: 12/31/2017

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.

Facility Name & ID Number Winchester House | STATE OF ILLINOIS # 0054049 | Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1	hrs	$ 142,863		$	$		$ 142,863	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	38,545					38,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	291,375					291,375	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				87,719		87,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2/Therapy Supplies	39-2					38,868		38,868	12
13	Other (specify): Lab/Xray/Equipment	39-3				62,377			62,377	13
14	TOTAL			$ 472,783		$ 62,377	$ 126,587		$ 661,747	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:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 1,231,964	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (127,494))	1,040,439		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	244,338		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Lake County	12,599		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,529,340	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	24,381		15
16	Equipment, at Historical Cost	30,896		16
17	Accumulated Depreciation (book methods)	(22,042)		17
18	Deferred Charges	36,928		18
19	Organization & Pre-Operating Costs	38,254		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,835)		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)**	$ 94,582	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,623,922	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 486,045	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120,589		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	400,905		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,007,539	$	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	1,663,289		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,663,289	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,670,828	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (46,906)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,623,922	$	48

***(See instructions.)**

Facility Name & ID Number Winchester House # 0054049 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (102,940)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (102,937)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	46,031	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	10,000	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)**	$ 56,031	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)**	$ (46,906)	24 *

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 20,101,106	1
2	Discounts and Allowances for all Levels	(12,770,978)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,330,128	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,716,945	6
7	Oxygen	20,707	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,737,652	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	174,651	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,788	19
20	Radiology and X-Ray	7,227	20
21	Other Medical Services	5,831	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 193,497	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,904	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,904	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lake County Progress Payments	1,166,743	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,166,743	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,442,924	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,509,854	31
32	Health Care	4,437,558	32
33	General Administration	3,365,182	33
	B. Capital Expense		
34	Ownership	44,934	34
	C. Ancillary Expense		
35	Special Cost Centers	662,550	35
36	Provider Participation Fee	376,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,396,893	40
41	**Income before Income Taxes (line 30 minus line 40)****	46,031	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 46,031	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,320,159	44
45	Private Pay - Net Inpatient Revenue	1,256,968	45
46	Medicare - Net Inpatient Revenue	38,351	46
47	Other-(specify) Managed Care	3,689,607	47
48	Other-(specify) Hospice	1,025,043	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,330,128	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: 1/1/2017 Ending: 12/31/2017

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	1,727	1,799	$ 106,077	$ 58.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,470	38,491	1,504,078	39.08	3
4	Licensed Practical Nurses	12,792	13,738	391,914	28.53	4
5	CNAs & Orderlies	87,346	97,217	1,674,973	17.23	5
6	CNA Trainees					6
7	Licensed Therapist	11,005	11,580	473,586	40.90	7
8	Rehab/Therapy Aides	4,680	5,257	60,080	11.43	8
9	Activity Director	4,089	4,282	109,237	25.51	9
10	Activity Assistants	7,110	7,974	113,777	14.27	10
11	Social Service Workers	1,892	1,960	138,621	70.73	11
12	Dietician	447	447	16,483	36.87	12
13	Food Service Supervisor	1,812	2,089	60,138	28.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,430	28,160	406,632	14.44	15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,080	66,964	32.19	17
18	Housekeepers	1,824	2,080	53,742	25.84	18
19	Laundry					19
20	Administrator	1,912	2,080	119,996	57.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,361	16,873	357,365	21.18	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	1,611	1,776	34,662	19.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,460	237,883	$ 5,688,325 *	$ 23.91	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	17,800	9-3	36
37	Medical Records Consultant	Monthly	21,177	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,603	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	18	830	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	828	11-3	44
45	Social Service Consultant	51	1,219	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	103	$ 54,457		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: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Prestel	Administrator	0	$ 119,996
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,996

B. Administrative - Other

Description	Amount
Management Fee - Transitional Care Management	$ 464,046
TOTAL (agree to Schedule V, line 17, col. 3)	$ 464,046
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Allison Consulting	Marketing Consultant	$ 28,796
Pinnacle Quality Insights	Customer Surveys	1,617
Procative Medical Review	5 Star and QM Data	1,249
UCC Filing	Data Processing	520
Stone McGuire & Siegel	Healthcare Consulting	311
David Siegel & Assoc.	Legal	1,975
Laner Muchin & WilliamsBaerson	Legal	45,321
Much Shelist	Legal	2,745
Polsinelli	Legal	15,055
Stone McGuire & Siegel	Legal	17,598
Paycom	Payroll Processing	61,113
FGMK, LLC	Accounting	36,240
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 212,540

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 213,679
Unemployment Compensation Insurance	
FICA Taxes	514,080
Employee Health Insurance	825,224
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	7,435
Other Employee Benefits	18,699
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,579,117

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	112,000
Health Care Worker Background Check	
(Indicate # of checks performed 133.9)	13,391
Patient Background Checks 79	790
Dues & Subscriptions	12,141
Marketing Costs	2,673
Licenses	6,873
Allocated TCM	1,659
Less: Public Relations Expense	( )
Non-allowable advertising	(2,673)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 146,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,761
Seminar Expense	30,571
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,332

* Attach copy of IMRF notifications

**See instructions.

Winchester House
#0054049
Travel Schedule
1/1/2017-12/31/2017

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	ADJ	TOTAL	ADJ
1/20/2017	H. Aguilar	Marketing	Hospital	Marketing	471.86	-471.86	0	ADJ
1/28/2017	A. Mackaye	Memory Unit Coord.	Hospital	Case Mgmt	159.08	0	159.08	
2/16/2017	H. Aguilar	Marketing	Hospital	Marketing	690.06	-690.06	0	ADJ
3/3/2017	H. Aguilar	Marketing	Hospital	Marketing	525	-525	0	ADJ
2/28/2017	Kathy	TCM	WH	Meetings/Work	49.22	0	49.22	
2/28/2017	Alvin	TCM	WH	Meetings/Work	34.28	0	34.28	
2/25/2017	H. Aguilar	Marketing	Hospital	Marketing	270.05	-270.05	0	ADJ
3/10/2017	H. Aguilar	Marketing	Hospital	Marketing	466.59	-466.59	0	ADJ
3/31/2017	H. Aguilar	Marketing	Hospital	Marketing	556.65	-556.65	0	ADJ
3/31/2017	Olivia	TCM	WH	Meetings/Work	96.3	0	96.3	
4/14/2017	H. Aguilar	Marketing	Hospital	Marketing	451.09	-451.09	0	ADJ
4/28/2017	H. Aguilar	Marketing	Hospital	Marketing	380.01	-380.01	0	ADJ
4/28/2017	A. Mackaye	Memory Unit Coord.	Hospital	Case Mgmt	255.3	0	255.3	
4/30/2017	Olivia	TCM	WH	Meetings/Work	121.24	0	121.24	
5/25/2017	H. Aguilar	Marketing	Hospital	Marketing	466.59	-466.59	0	ADJ
6/9/2017	H. Aguilar	Marketing	Hospital	Marketing	453.19	-453.19	0	ADJ
5/31/2017	Oliva	TCM	WH	Meetings/Work	48.15	0	48.15	
6/23/2017	A. Mackaye	Memory Unit Coord.	Hospital	Case Mgmt	59.92	0	59.92	
6/23/2017	H. Aguilar	Marketing	Hospital	Marketing	463.94	-463.94	0	ADJ
6/30/2017	Alvin P	TCM	WH	Meetings/Work	94	0	94	
6/30/2017	Olivia	TCM	WH	Meetings/Work	48.15	0	48.15	
7/7/2017	H. Aguilar	Marketing	Hospital	Marketing	490.72	-490.72	0	ADJ
7/21/2017	T. Kendzior	Clinical	Hospital	Case Mgmt	63.99	0	63.99	
7/21/2017	H. Aguilar	Marketing	Hospital	Marketing	381.03	-381.03	0	ADJ
7/31/2017	Alvin P	TCM	WH	Meetings/Work	61.82	0	61.82	
7/31/2017	H. Aguilar	Marketing	Hospital	Marketing	558.57	-558.57	0	ADJ
8/18/2017	H. Aguilar	Marketing	Hospital	Marketing	498.15	-498.15	0	ADJ
8/31/2017	H. Aguilar	Marketing	Hospital	Marketing	528.05	-528.05	0	ADJ
8/31/2017	Olivia	TCM	WH	Meetings/Work	48.15	0	48.15	
9/15/2017	H. Aguilar	Marketing	Hospital	Marketing	438.7	-438.7	0	ADJ
9/15/2017	M. Torres	Clinical	Hospital	Case Mgmt	71.58	0	71.58	
9/29/2017	H. Aguilar	Marketing	Hospital	Marketing	563.61	-563.61	0	ADJ
10/13/2017	H. Aguilar	Marketing	Hospital	Marketing	422.54	-522.54	-100	
10/27/2017	H. Aguilar	Marketing	Hospital	Marketing	490.15	-490.15	0	ADJ
10/31/2017	Alvin	TCM	WH	Meetings/Work	22.19	0	22.19	
10/31/2017	K. Dempsey	TCM	WH	Meetings/Work	27.82	0	27.82	
11/24/2017	H. Aguilar	Marketing	Hospital	Marketing	455.12	-455.12	0	ADJ
11/30/2017	Alvin P	TCM	WH	Meetings/Work	34.98	0	34.98	
11/30/2017	K. Dempsey	TCM	WH	Meetings/Work	27.82	0	27.82	
12/8/2017	H. Aguilar	Marketing	Hospital	Marketing	373.97	-373.97	0	ADJ
12/8/2017	D. Kayler	Clinical	Hospital	Case Mgmt	172.7	0	172.7	
12/21/2017	H. Aguilar	Marketing	Hospital	Marketing	392.03	-392.03	0	ADJ
12/21/2017	T. Kendzior	Clinical	Hospital	Case Mgmt	46.55	0	46.55	
12/30/2017	H. Aguilar	Marketing	Hospital	Marketing	393.76	-393.76	0	ADJ
					12724.67	-11281.43	1443.24	
	Other Transporation and Travel				2162	-1846	316	
	Rounding						2	
	Total Travel						1761.24	

Winchester House
#0054049
Legal Schedule
1/1/2017-12/31/2017

DATE	G/L ACCT. #	PAYEE/VENDOR	ADJ	AMOUNT	ADJ Amount	Adjusted Balance
12/1/2017	80550.00	David M. Siegel & Associates, LLC - Inv. 1		975		975
12/1/2017	80550.00	David M. Siegel & Associates, LLC - Inv. 2		1,000		1,000
5/31/2017	80550.00	Laner Muchin, LTD - April 2017 Fees		1,020		1,020
4/30/2017	80550.00	Laner Muchin, LTD - April 2017 Legal fees	ADJ	10,465	(10,465)	-
2/28/2017	80550.00	Laner Muchin, LTD - Charges for Feb 2017	ADJ	2,933	(2,933)	-
2/28/2017	80550.00	Laner Muchin, LTD - Charges for Jan 2017	ADJ	4,345	(4,345)	-
12/31/2016	80550.00	Laner Muchin, LTD - Dec 2016 Legal Fees	ADJ	1,658	(1,658)	-
1/31/2017	80550.00	Laner Muchin, LTD - Dec 2016 Legal Fees	ADJ	3,060	(3,060)	-
3/31/2017	80550.00	Laner Muchin, LTD - For Feb 2017 charges		510		510
3/31/2017	80550.00	Laner Muchin, LTD - For March 2017 charges	ADJ	7,150	(7,150)	-
1/31/2017	80550.00	Laner Muchin, LTD - J n 2017 Legal Fees	ADJ	1,941	(1,941)	-
6/30/2017	80550.00	Laner Muchin, LTD - June 2017 charges		1,658		1,658
4/30/2017	80550.00	Laner Muchin, LTD - March 2017 Legal fees		4,718		4,718
6/30/2017	80550.00	Laner Muchin, LTD - May 2017 charges		3,060		3,060
5/31/2017	80550.00	Laner Muchin, LTD - May 2017 Fees		638		638
12/31/2016	80550.00	Laner Muchin, LTD - November 2016 Legal Fees	ADJ	1,785	(1,785)	-
12/31/2016	80550.00	Much Shelist - Draft email and phone call w/Jackie 12/13/16	ADJ	696	(696)	-
5/31/2017	80550.00	Much Shelist - Legal Fees for May 2017		1,375		1,375
12/31/2016	80550.00	Much Shelist - Review Survey and draft email to client 12/05 6	ADJ	268	(268)	-
9/30/2017	80550.00	Much Shelist - Telephone call with Jackie		330		330
12/31/2017	80550.00	Much Shelist - Telephone Conf with Jackie		77		77
11/28/2016	80550.00	Polsinelli - Legal Fees	ADJ	880	(880)	-
12/21/2016	80550.00	Polsinelli - Legal Fees	ADJ	2,530	(2,530)	-
9/7/2017	80550.00	Polsinelli - SERVICES THRU 8/31/2017	ADJ	11,645	(11,645)	-
2/17/2017	80550.00	Recl Laner Muchin r fund	ADJ	(383)	383	-
7/31/2017	80550.00	Recl Prof fees - Laner Muchin		255		255
3/31/2017	80550.00	Recl prof fees - Williams & Baerson		510		510
4/30/2017	80550.00	Stone, McGuire & Si gel - Legal fees for A 2017	ADJ	2,403	(2,403)	-
11/30/2017	80550.00	Stone, McGuire & Siegel - NOVEMBER 2017		1,024		1,024
2/28/2017	80550.00	Stone, McGuire & Siegel - 6.25 hours for FEB 2017	ADJ	1,139	(1,139)	-
7/31/2017	80550.00	Stone, McGuire & Siegel - Fees for July 2017		1,703		1,703
6/30/2017	80550.00	Stone, McGuire & Siegel - Fees for June 2017		941		941
3/31/2017	80550.00	Stone, McGuire & Siegel - Legal Fees For March 17		1,680		1,680
12/31/2016	80550.00	Stone, McGuire & Siegel - Missed invoice	ADJ	2,000	(2,000)	-
10/31/2017	80550.00	Stone, McGuire & Siegel - Oct Fees		2,184		2,184
5/31/2017	80550.00	Stone, McGuire & Siegel legal fees for May 2017	ADJ	741	(741)	-
1/31/2017	80550.00	Stone, McGuire & Siegel legal fees Jan 2017	ADJ	2,858	(2,858)	-
8/31/2017	80550.00	Stone, McGuire & Sigel legal- Aug 2017		925		925
		Total		82,694	(58,112)	24,582

Winchester House
#0054049
Seminar Schedule
1/1/2017-12/31/2017

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
01/28/17	A. Mckaye	Dementia Communication	A. Mckaye	Memory unit coord		250.00	
01/28/17	A. Mckaye	Dementia Training	A.Mckaye	Memory unit coord		90.13	
01/31/17	PICC Me Vascular Solutions	PICC Insertion				1,050.00	
02/09/17	AMDA Conf.	AMDA Conference	J. Prestel	Administrator	Texas	1,168.40	ADJ
02/09/17	Sarah Glumm	F Tag Manual	S. Glumm	Administrative		98.42	
02/16/17	HCPro	50 PCS HIPAA Manual	All Staff			410.75	
02/16/17	Allied Health	Activities Director Certification	V. Rodgers	Activities		399.00	
02/28/17	TCM	EDEN Alternative Seminar	Various	Various	In House	5,850.00	
02/28/17	IHCA	IHCA Training for Olivia	Olivia	TCM	Online	82.50	
03/10/17	AMDA Conf.	AMDA Conference	Dr. Gupta	Medical Director	Texas	485.00	ADJ
03/31/17	IHCA	IHCA Training for Olivia	Olivia	TCM	Online	27.50	
05/12/17	D. Kayler	Documentation a Clinicians Roadmap	D. Kayler	Clinical		139.00	
05/31/17	PICC Me Vascular Solutions	PICC Insertion	Mcbride	Clinical		495.00	
05/31/17	HCPro	HCPRO Billing	TCM	Management		99.50	
05/08/17	Elderwerks Education Svcs	Resource Fair	Heidi Reich	marketing		300.00	ADJ
05/31/17	TCM	IHCA Seminar May	Olivia Christia	TCM		27.90	
06/23/17	TCLC Payroll	IL Continuity of Care				25.00	
06/27/17	PEL/VIP	Mock Code Inservices	Medical Staff	Clinical		375.00	
06/30/17	IHCA	Food Safety	Olivia Christia	TCM		91.50	
06/30/17	M. Goodman	Kinesio Course	M. Goodman	Therapy		278.00	
07/31/17	PICC Me Vascular Solutions	Insertion	Baran	Clinical		450.00	
07/25/17	CE Solutions	ONLINE Training	Various	Various	ONLINE	4,382.81	
08/24/17	Pathway Health	Restortative Rehab	Tisa Matthew	Rehab		1,299.00	
09/28/17	Hedy Duggan	Workshop	2 Attendees			110.00	
09/30/17	TCM	IHCA	Olivia Christia	TCM	Online	27.50	
10/31/17	Petty Cash	Essential Oil Training		Therapy		110.00	
10/13/17	IOLTA	ILOTA Conf.	R. Guzman	Activies Coord	Normal, IL	275.00	
10/27/17	IOLTA	ILOTA Conf.	D. Kayler	Therapy director	Normal, IL	361.40	
10/31/17	TCM	Nursing Care Manual	Various	Clinical		343.30	
11/30/17	TCM	Indeed Conference	Terri	Recruiter		199.50	
12/06/17	CE Solutions	ONLINE Training	Various	Various	ONLINE	185.94	
12/31/17	TCM	PIE Conference				1,028.70	
						20,515.75	
					Adjustments	(1,953.40)	
					ALLOCATED TCM	12,009.00	
					Adjusted Total	30,571.35	

Facility Name & ID Number **Winchester House** **#** **0054049** **Report Period Beginning:** **1/1/2017** **Ending:** **12/31/2017**

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? **N/A**

(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 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** 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. $ **376,815**
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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Line 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. $ **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