FOR BHF USE

LL1

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

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

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 1/1/2017 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) 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: 1/1/2017 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 _____

	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	11,315	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,370	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			4,065	4,065	8
9	SNF/PED					9
10	ICF	40,693	2,532		43,225	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,693	2,532	4,065	47,290	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.89%

D. How many bed reserve days during this year were paid by the Department?
0 (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] 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 3,821

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: 12/31/17 Fiscal Year: 12/31/17

* 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: 1/1/2017 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	229,356	15,648	12,429	257,433		257,433		257,433			1
2	Food Purchase		270,355		270,355		270,355	(400)	269,955			2
3	Housekeeping	175,738	40,200		215,938		215,938		215,938			3
4	Laundry	65,262	8,593		73,855		73,855		73,855			4
5	Heat and Other Utilities			211,773	211,773		211,773	714	212,487			5
6	Maintenance	39,500		47,030	86,530		86,530	8,447	94,977			6
7	Other (specify):* Waste Removal			14,035	14,035		14,035		14,035			7
8	TOTAL General Services	509,856	334,796	285,267	1,129,919		1,129,919	8,761	1,138,680			8
	B. Health Care and Programs											
9	Medical Director			12,553	12,553		12,553		12,553			9
10	Nursing and Medical Records	1,690,889	113,809	24,951	1,829,649		1,829,649	83,615	1,913,264			10
10a	Therapy	153,360	3,048	18,539	174,947		174,947	(2,039)	172,908			10a
11	Activities	102,658		1,364	104,022		104,022		104,022			11
12	Social Services	141,557		10,625	152,182		152,182		152,182			12
13	CNA Training											13
14	Program Transportation			1,967	1,967		1,967		1,967			14
15	Other (specify):* Mgmt Co Benefits Alloc							15,244	15,244			15
16	TOTAL Health Care and Programs	2,088,464	116,857	69,999	2,275,320		2,275,320	96,820	2,372,140			16
	C. General Administration											
17	Administrative	201,160		458,225	659,385		659,385	(342,853)	316,532			17
18	Directors Fees											18
19	Professional Services			130,062	130,062		130,062	(17,161)	112,901			19
20	Dues, Fees, Subscriptions & Promotions			20,827	20,827		20,827	(1,246)	19,581			20
21	Clerical & General Office Expenses	209,542	23,640	130,009	363,191		363,191	131,970	495,161			21
22	Employee Benefits & Payroll Taxes			428,498	428,498		428,498		428,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,682	1,682		1,682	199	1,881			24
25	Other Admin. Staff Transportation			7,180	7,180		7,180	2,467	9,647			25
26	Insurance-Prop.Liab.Malpractice			89,430	89,430		89,430	1,447	90,877			26
27	Other (specify):* Mgmt Co Benefits Alloc							39,337	39,337			27
28	TOTAL General Administration	410,702	23,640	1,265,913	1,700,255		1,700,255	(185,840)	1,514,415			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,009,022	475,293	1,621,179	5,105,494		5,105,494	(80,259)	5,025,235			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: 1/1/2017 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							239,418	239,418			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,048	50,048		50,048	931,675	981,723			32
33	Real Estate Taxes			73,503	73,503		73,503		73,503			33
34	Rent-Facility & Grounds			1,059,401	1,059,401		1,059,401	(1,045,270)	14,131			34
35	Rent-Equipment & Vehicles			44,108	44,108		44,108	1,603	45,711			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,227,060	1,227,060		1,227,060	127,426	1,354,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,540	619,846	736,386		736,386	(156,545)	579,841			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,448	345,448		345,448		345,448			42
43	Other (specify):* **Disallowed Costs**	9,429	4,814	198,435	212,678		212,678	(212,678)				43
44	**TOTAL Special Cost Centers**	9,429	121,354	1,163,729	1,294,512		1,294,512	(369,223)	925,289			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,018,451	596,647	4,011,968	7,627,066		7,627,066	(322,056)	7,305,010			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: 1/1/2017 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	(9,845)	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	237,530	30		9
10	Interest and Other Investment Income	(6,438)	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	(9,444)	43		18
19	Entertainment				19
20	Contributions	(23,400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(29,427)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,468)	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	(26,540)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,032)		$	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)	(317,024)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (317,024)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (322,056)		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

STATE OF ILLINOIS

Winfield Woods Hlthcare Ctr

ID# **0052100**

Report Period Beginning: **1/1/2017**

Ending: **12/31/2017**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (400)	2	1
2	Marketing Salaries	(9,429)	43	2
3	Marketing Expense	(23,092)	43	3
4	Expense Repairs under $2,500	10,894	6	4
5	PAC Dues	(1,973)	20	5
6	Capitalize Repairs & Maint over $2,500	(2,540)	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**	(26,540)		49

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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
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		Pershing Gardens Realty, LLC	100.00%	$ 930,859	$ 930,859	1
2	V	34	Rent-Facility & Grounds	1,059,401	Pershing Gardens Realty, LLC	100.00%		(1,059,401)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,059,401			$ 930,859	$ * (128,542)	14

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

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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%	$ 714	$ 714	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	93	93	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	91,180	91,180	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	15,244	15,244	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	458,225	Premier Healthcare Management, LLC	100.00%	92,668	(365,557)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	22,704	22,704	22
23	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	0		23
24	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	5,451	5,451	24
25	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	535	535	25
26	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	127,770	127,770	26
27	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	199	199	27
28	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,666	1,666	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	35,541	35,541	29
30	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	3,796	3,796	30
31	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0		31
32	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	14,131	14,131	32
33	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	1,603	1,603	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 458,225			$ 413,295	$ * (44,930)	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: 1/1/2017 Ending: 12/31/2017

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	$ 12,366	Premier Healthcare Supplies, LLC	100.00%	$ 4,801	$ (7,565)	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			$ 12,366			$ 4,801	$ * (7,565)	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: 1/1/2017 Ending: 12/31/2017

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	10A	Therapy	$ 2,039	REX Therapeutics	100.00%	$	$ (2,039)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	6,815	6,815	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	192	192	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	4,200	4,200	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	801	801	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	1,447	1,447	20
21	V	30	Depreciation		REX Therapeutics	100.00%	1,888	1,888	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	7,254	7,254	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	5,397	5,397	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	16,559	16,559	24
25	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	51,683	51,683	25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	389,638	389,638	27
28	V	39	Contract Therapy	619,822	REX Therapeutics	100.00%		(619,822)	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			$ 621,861			$ 485,874	$ * (135,987)	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: 1/1/2017 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	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

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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	David Cheplowitz	Shareholder	Administrative	37.68%	See Att Sch 7A	4.41	11%	Alloc Salary	$ 19,412	17-7	1
2	Barak Baver	Shareholder	Administrative	37.68%	See Att Sch 7A	4.41	11%	Alloc Salary	19,412	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	4.41	11%	Alloc Salary	4,874	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	$ 43,698		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 Winfield Woods Hlthcare Ctr # 0052100 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: 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	428,856	12	$ 6,472	$	47,290	$ 714	1
2	6	Maintenance	Census Days	428,856	12	843		47,290	93	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	593,374	47,290	91,180	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	239,535		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203		47,290	15,244	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047			0	6
7	17	Administrative	Census Days	428,856	12	840,373	840,373	47,290	92,668	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	147,750	47,290	22,704	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	133,577		0	9
10	19	Professional Services	Census Days	428,856	12	49,430		47,290	5,451	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850		47,290	535	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	1,087,471	47,290	127,770	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803		47,290	199	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107		47,290	1,666	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307		47,290	35,541	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702		47,290	3,796	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332			0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146		47,290	14,131	18
19	35	Equipment Rental	Census Days	428,856	12	14,538		47,290	1,603	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,843,091	$ 3,042,080		$ 413,295	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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: 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	161,406	12	$ 65,860	$	11,766	$ 4,801	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					$ 65,860	$		$ 4,801	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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: 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	5,071,121	7	$ 55,562	$	622,024	$ 6,815	1
2	20	Fees and Subscriptions	Therapy Revenue	5,071,121	7	1,569		622,024	192	2
3	21	Clerical & General Office Exp	Therapy Revenue	5,071,121	7	34,248		622,024	4,200	3
4	25	Other Admin Staff Transp	Therapy Revenue	5,071,121	7	6,528		622,024	801	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	5,071,121	7	11,796		622,024	1,447	5
6	30	Depreciation	Therapy Revenue	5,071,121	7	15,390		622,024	1,888	6
7	32	Interest Expense	Therapy Revenue	5,071,121	7	59,135		622,024	7,254	7
8	39	Therapy Consultant	Therapy Revenue	5,071,121	7	44,000		622,024	5,397	8
9	39	Therapy Management Wages	Therapy Revenue	5,071,121	7	135,002	135,002	622,024	16,559	9
10	39	Allocated Employee Benefits	Therapy Revenue	5,071,121	7	421,361		622,024	51,683	10
11										11
12	39	Therapy Wages	Direct Allocation	3,215,952	4	3,215,952	3,215,952	389,638	389,638	12
13	39	Contract Therapy	Direct Allocation	396,932	4	396,932				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					$ 4,397,475	$ 3,350,954		$ 485,874	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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** 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	Bank Leumi		X	Mortgage	$21,720.00	5/31/2016	12,480,000	12,089,040	5/31/2021	0.0350	726,073	1
2	Bank Leumi		X	Mortgage	$6,130.00	5/31/2016	3,520,000	3,409,660	5/31/2021	0.0350	204,786	2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,375,434			49,004	6
7												7
8												8
9	TOTAL Facility Related				$27,850.00		$ 16,000,000	$ 16,874,134			$ 979,863	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			7,254	11
12								Offset Interest Income			(6,438)	12
13								Other Interest Expense			1,044	13
14	TOTAL Non-Facility Related						$	$			$ 1,860	14
15	TOTALS (line 9+line14)						$ 16,000,000	$ 16,874,134			$ 981,723	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:** 1/1/2017 **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.**		$ 88,336	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.)	2016	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (88,336)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 161,839	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.		$ 73,503	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	72,663	8
	2013	73,455	9
	2014	74,020	10
	2015	76,432	11
	2016	77,477	12

Accrual based on prior year tax bill.

	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 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 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.	04-14-201-003	Long Term Care Property	$ 77,476.56	$ 77,476.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,476.56	$ 77,476.56

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 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 Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 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	138		2015	1971	$ 4,400,000	$	35	$ 125,714	$ 125,714	$ 377,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rci Delayed Egress Mag Lock With Internal Sounder			2013	3,716		20	186	186	3,097	9
10	5 New Wall Outlets: 3 On Second Floor, 2 On First Floor			2013	2,800		20	140	140	618	10
11	Electric Installation Of Emergency Outlets			2013	30,100		20	1,505	1,505	4,367	11
12	Landscaping			2014	3,400		20	170	170	437	12
13	Elevator Door Repair			2014	3,750		20	188	188	474	13
14	Rooftop Replacement			2014	11,268		20	563	563	1,368	14
15	Replace Water Heater/Pipes/Valves For Kitchen/Laundry Room			2015	7,749		20	387	387	1,161	15
16	Installation Of Electrical Sources/Wiring In Mechanical Room			2015	6,455		20	323	323	969	16
17	Rebuilding Of Chimney/Tuckpointing			2015	8,700		20	435	435	1,305	17
18	Instal Of New Heat Exchanger/New Burners/Rollout Switch			2015	7,438		20	372	372	1,116	18
19	Wanderguard Id/Wall Mounts/Signaling Device/Magnetic Locks			2015	29,745		20	1,487	1,487	4,461	19
20	Install Roam Alert System/Door Controller/Electrical			2015	31,619		20	1,581	1,581	4,743	20
21	Install Roam Alert Eco Door Control/Excitor Antenna/Annunciator			2015	21,705		20	1,085	1,085	3,255	21
22	Generator			2015	3,136		20	157	157	785	22
23	Generator			2015	3,136		20	157	157	785	23
24	Installed New Motor, Housing and Backplate at RTU #1			2016	2,529		20	126	126	189	24
25	Installed 16 New Smoke/Fire Damper Motors			2016	8,221		20	411	411	617	25
26	Clean, Patch, Seal and Stripe Parking Lot			2016	5,700		20	285	285	428	26
27	Re-pipe Generator Feed			2016	3,428		20	171	171	257	27
28	Parking Lot Repaving			2016	5,352		20	268	268	402	28
29	Install 9 Door Alarms and Nursing Station Annunciators			2016	6,295		20	315	315	472	29
30	Install Emergency Call System			2016	18,600		20	930	930	1,395	30
31	Elevator Repairs-Replaced Micro-chip, Adjust Rollers, Rebuilt Starter			2016	3,157		20	158	158	237	31
32	Repairs/Maintenance on HVAC Units			2017	8,015		20	200	200	200	32
33	Install Electric Booster Heater			2017	3,435		20	86	86	86	33
34	Replace Compressor in HVAC Unit			2017	4,357		20	109	109	109	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 Winfield Woods Hlthcare Ctr # 0052100 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	Allocated from Premier Healthcare Management, LLC	2013	2,745		20	137	137	575	46
47									47
48									48
49	Allocated from REX Therapeutics					1,888	1,888		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)		$ 4,646,551	$		$ 139,534	$ 139,534	$ 411,050	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: 1/1/2017 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	$ 970,024	$	$ 97,002	$ 97,002	10	$ 335,591	71
72	Current Year Purchases	57,630		2,882	2,882	10	2,882	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,027,654	$	$ 99,884	$ 99,884		$ 338,473	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	N/A									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)	$ 6,134,205	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)	$ 239,418	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 239,418	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 749,523	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.

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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:

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.				14,131			5
6								6
7	TOTAL				$ 14,131 **			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: $ 17,211 Description: Nursing 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	See Page 14A			26,897	18
19					19
20	Allocated from Management Co.			1,603	20
21	TOTAL		$	$ 28,500	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: Winfield Woods Hlthcare Ctr
IDPH License ID Number: 0052100
Fiscal Year End: 12/31/2017

Schedule 14A

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	1,608.45	13,259	18
19	Facility	2014 Ford Elkhart	772.39	8,513	19
20	Facility	2017 Lexus RX350	1,249.94	5,125	20
21	TOTAL		$ 3,630.78	$ 26,897	21

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr | STATE OF ILLINOIS # 0052100 | 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 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(7)	2724	hrs	$ 118,450		$	$	2,724	$ 118,450	1
2	Licensed Speech and Language Development Therapist	39(7)	592	hrs	25,729				592	25,729	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(7)	6026	hrs	262,018				6,026	262,018	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				115,737		115,737	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Rehab Supplies	10A(2)						3,048		3,048	12
13	Other (specify): See Attached Scheule 16A						57,907			57,907	13
14	TOTAL				$ 406,197		$ 57,907	$ 118,785	9,342	$ 582,889	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: **12/31/2017**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Medical Supplies - MCA	39(2)	803
Lab &Xray	39(3)	24
Therapy Consultant	39(7)	5,397
Employee Benefits Allocated fro	39(7)	51,683
Total - Line 13		**57,907**

STATE OF ILLINOIS

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 **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	$ (138,576)	$ (138,561)	1
2	Cash-Patient Deposits	3,007	3,007	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 534,698)	1,369,940	1,369,940	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,336	11,336	6
7	Other Prepaid Expenses	(92,548)	(92,548)	7
8	Accounts Receivable (owners or related parties)	3,850,984	8,066,775	8
9	Other(specify): Due from prior owner	23,105	23,105	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,027,248	$ 9,243,054	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	204,666	246,551	15
16	Equipment, at Historical Cost	377,328	1,027,654	16
17	Accumulated Depreciation (book methods)	(230,842)	(749,523)	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	(1,421)	2,150,949	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 366,207	$ 7,552,107	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,393,455	$ 16,795,161	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,414,706	$ 1,587,028	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,552	4,552	28
29	Short-Term Notes Payable	1,375,434	4,785,094	29
30	Accrued Salaries Payable	158,901	158,901	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,133	7,133	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,839	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	34,220	34,220	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,994,946	$ 6,738,767	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,089,040	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)**	$	$ 12,089,040	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,994,946	$ 18,827,807	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,398,509	$ (2,032,646)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,393,455	$ 16,795,161	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Winfield Woods Hlthcare Ctr**
IDPH License ID Number: **0052100**
Fiscal Year End: **12/31/2017**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	(1,421)	200,949
Intangibles		1,950,000
Total - Line 23	**(1,421)**	**2,150,949**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 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**	$ 1,122,647	1
2	Restatements (describe):		2
3	**Post closing adjustments**	(69,124)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,053,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,546,271	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(201,285)	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)**	$ 1,344,986	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)**	$ 2,398,509	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: 1/1/2017 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	$ 8,223,749	1
2	Discounts and Allowances for all Levels	682,913	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,906,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	259,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 259,800	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	37	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)**	$ 37	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,438	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,438	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	400	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 400	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,173,337	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,129,919	31
32	Health Care	2,275,320	32
33	General Administration	1,700,255	33
	B. Capital Expense		
34	Ownership	1,227,060	34
	C. Ancillary Expense		
35	Special Cost Centers	949,064	35
36	Provider Participation Fee	345,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,627,066	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,546,271	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,546,271	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,111,484	44
45	Private Pay - Net Inpatient Revenue	481,668	45
46	Medicare - Net Inpatient Revenue	2,284,913	46
47	Other-(specify) Insurance	28,597	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,906,662	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: 1/1/2017 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	1,969	2,337	$ 118,211	$ 50.58	1
2	Assistant Director of Nursing	950	967	35,593	36.81	2
3	Registered Nurses	5,382	5,848	186,671	31.92	3
4	Licensed Practical Nurses	22,568	23,933	618,769	25.85	4
5	CNAs & Orderlies	42,548	45,591	644,283	14.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,683	8,499	153,360	18.04	8
9	Activity Director					9
10	Activity Assistants	5,783	6,363	102,658	16.13	10
11	Social Service Workers	6,697	7,067	141,557	20.03	11
12	Dietician					12
13	Food Service Supervisor	2,355	2,539	52,540	20.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,504	16,278	176,816	10.86	15
16	Dishwashers					16
17	Maintenance Workers	1,868	2,196	39,500	17.99	17
18	Housekeepers	16,730	18,410	175,738	9.55	18
19	Laundry	6,109	6,765	65,262	9.65	19
20	Administrator	1,912	2,080	132,621	63.76	20
21	Assistant Administrator	1,896	2,008	68,539	34.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,043	8,915	209,542	23.50	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	240	240	4,430	18.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	2,657	2,825	92,361	32.69	33
34	TOTAL (lines 1 - 33)	149,894	162,861	$ 3,018,451 *	$ 18.53	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	$ 12,429	L1, C3	35
36	Medical Director	Monthly	12,553	L9, C3	36
37	Medical Records Consultant	Monthly	1,238	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	23,713	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	10,625	L12, C3	45
46	Other(specify)				46
47	Rehab Consultant	Monthly	16,500	L10a, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 77,058		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

Winfield Woods Hlthcare Ctr

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,313	2,481	82,932	33.43
Marketing		344	344	9,429	27.41
	TOTAL	2,657	2,825	92,361	

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nora O'Gorman	Administrator	0	$ 132,621
Brian Gallagher	Asst Admin	0	68,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 201,160

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 458,225
TOTAL (agree to Schedule V, line 17, col. 3)	$ 458,225
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 30,770
Richard Peelo & Associates, Inc	Accounting	2,100
CohnReznick LLP	Accounting	7,604
Sharon Lofgren	Medicare Billing	3,600
Singer Networks L.L.C.	Data Processing	6,517
HDSI	Data Processing	1,899
ADP	Payroll Processing	805
E-Solutions	Data Processing	6,315
Ability Network Inc	Data Processing	1,092
Matrixcare	Data Processing	32,740
See Attached Schedule 21A		36,620
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 130,062

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,325
Unemployment Compensation Insurance	44,589
FICA Taxes	223,661
Employee Health Insurance	108,037
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,886
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,498

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	6,050
Health Care Worker Background Check	
(Indicate # of checks performed 147)	7,635
Patient Background Checks 18	180
Dues & Subscriptions	1,803
Licenses & Permits	1,212
IL Council on LTC	1,974
Allocated from Management Co.	727
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,682
Allocated from Management Co.	199
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,881

* 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: **12/31/2017**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Terrill Consulting Services, Inc.	Billing Consultant	18,645
Paycor	Payroll Processing	16,423
HCCI	Financial Consultant	987
IIT/SORCETECH	Reversal-Data Processing	(230)
Change Healthcare	Data Processing	795
Total		**36,620**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **1,974 IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a politica
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?

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,496** 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 fo
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 Departmen
during this cost report period. $ **345,448**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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
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