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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 1/1/2018 to 12/31/2018 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: 1/1/2018 Ending: 12/31/2018

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	10,210	4,951	28,785	43,946	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,210	4,951	28,785	43,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.75%

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 2,344

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: 1/1/2018 Ending: 12/31/2018

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	476,862	24,378	11,311	512,551		512,551		512,551			1
2	Food Purchase		282,418		282,418		282,418		282,418			2
3	Housekeeping	53,841	24,890	335,985	414,716		414,716		414,716			3
4	Laundry		8,985	149,799	158,784		158,784		158,784			4
5	Heat and Other Utilities			21,790	21,790		21,790		21,790			5
6	Maintenance	73,535		38,742	112,277		112,277		112,277			6
7	Other (specify):*											7
8	TOTAL General Services	604,238	340,671	557,627	1,502,536		1,502,536		1,502,536			8
	B. Health Care and Programs											
9	Medical Director			18,200	18,200		18,200		18,200			9
10	Nursing and Medical Records	3,694,229	238,153	23,742	3,956,124		3,956,124		3,956,124			10
10a	Therapy	86,134			86,134		86,134		86,134			10a
11	Activities	175,261	1,499	552	177,312		177,312		177,312			11
12	Social Services	127,075		1,669	128,744		128,744		128,744			12
13	CNA Training											13
14	Program Transportation			6,333	6,333		6,333		6,333			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,082,699	239,652	50,496	4,372,847		4,372,847		4,372,847			16
	C. General Administration											
17	Administrative	122,791		452,485	575,276		575,276	(440,010)	135,266			17
18	Directors Fees											18
19	Professional Services			217,062	217,062		217,062	(60,116)	156,946			19
20	Dues, Fees, Subscriptions & Promotions			138,976	138,976		138,976	(94,249)	44,727			20
21	Clerical & General Office Expenses	435,118	209,943	194,125	839,186		839,186	406,562	1,245,748			21
22	Employee Benefits & Payroll Taxes			1,614,045	1,614,045		1,614,045		1,614,045			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,016	18,016		18,016	(4,071)	13,945			24
25	Other Admin. Staff Transportation							37,453	37,453			25
26	Insurance-Prop.Liab.Malpractice			177,916	177,916		177,916	13,098	191,014			26
27	Other (specify):*							182,830	182,830			27
28	TOTAL General Administration	557,909	209,943	2,812,625	3,580,477		3,580,477	41,497	3,621,974			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,244,846	790,266	3,420,748	9,455,860		9,455,860	41,497	9,497,357			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: 1/1/2018 Ending: 12/31/2018

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			11,207	11,207		11,207	(4,815)	6,392			30
31	Amortization of Pre-Op. & Org.			12,132	12,132		12,132		12,132			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			11,153	11,153		11,153	13,223	24,376			34
35	Rent-Equipment & Vehicles			15,943	15,943		15,943		15,943			35
36	Other (specify):*											36
37	**TOTAL Ownership**			50,435	50,435		50,435	8,408	58,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	469,934	125,377	73,772	669,083		669,083		669,083			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			372,488	372,488		372,488		372,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	469,934	125,377	446,260	1,041,571		1,041,571		1,041,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,714,780	915,643	3,917,443	10,547,866		10,547,866	49,905	10,597,771			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: 1/1/2018 Ending: 12/31/2018

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	(5,047)	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	(2,240)	21		19
20	Contributions	(1,225)	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	(135,746)	21		24
25	Fund Raising, Advertising and Promotional	(92,983)	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	(85,350)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (322,591)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (322,591)		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal Fees	$ (39,694)	19	1
2	Bank Fees	(7,286)	21	2
3	Marketing Consultant	(24,925)	19	3
4	Non-Allowable IHCA Lobbying Expense	(3,107)	20	4
5	Non-Allowable Travel	(10,138)	24	5
6	Non-Allowable Seminar	(200)	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**	(85,350)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(440,010)	0	0	0	0	0	0	0	0	0	(440,010)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(64,619)	4,503	0	0	0	0	0	0	0	0	0	(60,116)	19
20	Fees, Subscriptions & Promotions	(96,090)	1,841	0	0	0	0	0	0	0	0	0	(94,249)	20
21	Clerical & General Office Expenses	(146,497)	553,059	0	0	0	0	0	0	0	0	0	406,562	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	(10,338)	6,267	0	0	0	0	0	0	0	0	0	(4,071)	24
25	Other Admin. Staff Transportation	0	37,453	0	0	0	0	0	0	0	0	0	37,453	25
26	Insurance-Prop.Liab.Malpractice	0	13,098	0	0	0	0	0	0	0	0	0	13,098	26
27	Other (specify):*	0	182,830	0	0	0	0	0	0	0	0	0	182,830	27
28	**TOTAL General Administration**	(317,544)	359,041	0	0	0	0	0	0	0	0	0	41,497	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(317,544)	359,041	0	0	0	0	0	0	0	0	0	41,497	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(5,047)	232	0	0	0	0	0	0	0	0	0	(4,815)	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	13,223	0	0	0	0	0	0	0	0	0	13,223	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**	(5,047)	13,455	0	0	0	0	0	0	0	0	0	8,408	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)**	(322,591)	372,496	0	0	0	0	0	0	0	0	0	49,905	45

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
KCB Real Estate VI LP	80%	None				
IH Mundelein, LLC	15%	None		Transitional Care Management		Management Co.
Lockwood Investments, LLC	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		$ 12,475	$ 12,475	1
2	V	19	Professional Fees		Transitional Care Management, LLC		4,503	4,503	2
3	V	20	Dues & Subscriptions		Transitional Care Management, LLC		1,841	1,841	3
4	V	21	A&G Salary - Non-Owners		Transitional Care Management, LLC		513,048	513,048	4
5	V	21	A&G		Transitional Care Management, LLC		40,011	40,011	5
6	V	24	Seminar		Transitional Care Management, LLC		6,267	6,267	6
7	V	25	Admin. Staff Travel		Transitional Care Management, LLC		37,453	37,453	7
8	V	26	Insurance		Transitional Care Management, LLC		13,098	13,098	8
9	V	27	Employee Benefits		Transitional Care Management, LLC		182,830	182,830	9
10	V	30	Depreciation		Transitional Care Management, LLC		232	232	10
11	V	34	Building Rent		Transitional Care Management, LLC		13,223	13,223	11
12	V								12
13	V	17	Management Fee	452,485	Transitional Care Management, LLC			(452,485)	13
14	Total			$ 452,485			$ 824,981	$ * 372,496	14

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Administrative	Administrative	0.06	0	0	0.00	Allocated	$ 12,475	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	$ 12,475		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: 1/1/2018 Ending: 2/31/2018

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	71,209		$ 20,214	$ 20,214	43,946	$ 12,475	1
2	19	Professional Fees	Patient Days	71,209		7,296		43,946	4,503	2
3	20	Dues, Subscriptions	Patient Days	71,209		2,983		43,946	1,841	3
4	21	A&G Salary - Non Owner	Patient Days	71,209		831,330	831,330	43,946	513,048	4
5	21	A&G	Patient Days	71,209		64,833		43,946	40,011	5
6	24	Seminar	Patient Days	71,209		10,155		43,946	6,267	6
7	25	Admin. Staff Travel	Patient Days	71,209		60,689		43,946	37,454	7
8	26	Insurance	Patient Days	71,209		21,224		43,946	13,098	8
9	27	Employee Benefits	Patient Days	71,209		295,441		43,946	182,329	9
10	30	Depreciation	Patient Days	71,209		376		43,946	232	10
11	34	Building Rent	Patient Days	71,209		21,426		43,946	13,223	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					$ 1,335,967	$ 851,544		$ 824,481	25

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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				32,000				6
7												7
8												8
9	TOTAL Facility Related						$	$ 32,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 32,000			$	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

Facility Pays Real Estate Tax as part of rent

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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: _____

3. Current Period Amortization: 12,132 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: 1/1/2018 Ending: 12/31/2018

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)	5,902	9
10	Lights - Entire Facility			2015	3,225	645	20	161	(484)	2,043	10
11	Lights - Entire Facility			2015	3,225	645	20	161	(484)	2,036	11
12	B-Wing Improvements			2015	4,550	910	20	228	(682)	2,863	12
13	1st Floor patient room Floor, Walls			2015	8,096	1,619	20	405	(1,214)	5,077	13
14	Lights - Entire Facility			2016	3,060	612	20	153	(459)	446	14
15	Painting 1st floor patient Room			2016	2,225	445	20	111	(334)	324	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: 1/1/2018 Ending: 12/31/2018

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)	$ 18,691	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: 1/1/2018 Ending: 12/31/2018

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	$ 4,455	$ 4,168	$ (287)	5	$ 14,986	71
72	Current Year Purchases	1,519		304	304		304	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 23,035	$ 4,455	$ 4,472	$ 17		$ 15,290	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)	$ 56,796	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,207	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 6,160	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,047)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 33,981	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: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Lake County

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		224		$ 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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,153 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: 1/1/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	hrs	$ 138,955		$	$		$ 138,955	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	52,187					52,187	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	278,792					278,792	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				87,951		87,951	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2/Therapy Supplies	39-2					37,426		37,426	12
13	Other (specify): Lab/X-Ray/Equipment	39-3				73,772			73,772	13
14	TOTAL			$ 469,934		$ 73,772	$ 125,377		$ 669,083	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: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 524,008	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (162,417))	557,560		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	203,822		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Lake County	9,140		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,294,530	$	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	32,415		16
17	Accumulated Depreciation (book methods)	(33,250)		17
18	Deferred Charges	27,530		18
19	Organization & Pre-Operating Costs	38,254		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,957)		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)**	$ 63,373	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,357,903	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 528,966	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	97,591		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	420,914		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)**	$ 1,047,471	$	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	32,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 32,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,079,471	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (81,940)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 997,531	$	48

***(See instructions.)**

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (46,906)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (46,906)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	325,338	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(360,372)	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)**	$ (35,034)	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)**	$ (81,940)	24 *

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

Facility Name & ID Number Winchester House # 0054049 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 19,585,645	1
2	Discounts and Allowances for all Levels	(12,468,725)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,116,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,669,661	6
7	Oxygen	9,391	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,679,052	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	149,367	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,357	19
20	Radiology and X-Ray	4,799	20
21	Other Medical Services	76,883	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 241,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,537	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,537	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Lake County Progress Payments	1,823,289	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,823,289	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,873,204	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,502,536	31
32	Health Care	4,372,847	32
33	General Administration	3,580,477	33
	B. Capital Expense		
34	Ownership	50,435	34
	C. Ancillary Expense		
35	Special Cost Centers	669,083	35
36	Provider Participation Fee	372,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,547,866	40
41	**Income before Income Taxes (line 30 minus line 40)****	325,338	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 325,338	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,631,720	44
45	Private Pay - Net Inpatient Revenue	1,561,427	45
46	Medicare - Net Inpatient Revenue	372,874	46
47	Other-(specify) Managed Care	2,479,230	47
48	Other-(specify) Hospice	1,071,669	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,116,920	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: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,053	2,503	$ 93,094	$ 37.19	1
2	Assistant Director of Nursing	1,944	2,043	43,379	21.23	2
3	Registered Nurses	35,341	37,500	1,433,902	38.24	3
4	Licensed Practical Nurses	12,530	13,308	395,293	29.70	4
5	CNAs & Orderlies	89,153	97,049	1,692,158	17.44	5
6	CNA Trainees					6
7	Licensed Therapist	11,202	11,910	469,934	39.46	7
8	Rehab/Therapy Aides	3,957	4,619	86,134	18.65	8
9	Activity Director	3,542	3,884	65,231	16.79	9
10	Activity Assistants	6,965	7,952	110,030	13.84	10
11	Social Service Workers	1,632	1,782	127,075	71.31	11
12	Dietician	320	320	33,772	105.54	12
13	Food Service Supervisor	1,772	1,912	60,242	31.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,058	26,698	382,848	14.34	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,080	73,535	35.35	17
18	Housekeepers	1,936	2,080	53,841	25.89	18
19	Laundry					19
20	Administrator	1,989	2,189	122,791	56.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,220	16,584	435,118	26.24	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	1,521	1,750	36,403	20.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,095	236,163	$ 5,714,780 *	$ 24.20	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	18,200	9-3	36
37	Medical Records Consultant	Monthly	11,524	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,218	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	552	11-3	44
45	Social Service Consultant	70	1,669	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	86	$ 44,163		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: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Prestel	Administrator	0	$ 122,791
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 122,791

B. Administrative - Other

Description	Amount
Management Fee - Transitional Care Management	$ 452,485
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 452,485

C. Professional Services

Vendor/Payee	Type	Amount
Allison Consulting	Marketing Consultant	$ 24,925
See Attached	Legal	64,600
FGMK, LLC	Accounting/Consulting	49,599
Paycom	Payroll Processing	68,997
Stone, McGuire	Compliance	7,941
TCM	HR Consultant	1,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 217,062

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 184,193
Unemployment Compensation Insurance	
FICA Taxes	594,978
Employee Health Insurance	806,554
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	4,873
Other Employee Benefits	23,447
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,614,045

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	106,150
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 92	925
Dues & Subscriptions	21,567
Licenses	2,967
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 131,609

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,154
Seminar Expense	10,791
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,945

* Attach copy of IMRF notifications

**See instructions.

Winchester House
#0054049
Travel Schedule
1/1/2018-12/31/2018

DATE	EMPLOYEE NAME	JOB DESCRIPTIO	DESTINATIC	PURPOSE OF TRIP	Expense	ADJ	TOTAL	ADJ
43399	Heidi	Marketing	Tolls	Marketing	40.00	(40.00)	-	ADJ
43399	J. Prestel	Administrator	Hotel Springfie	Seminar	161.59	-	161.59	
43441	Heidi	Marketing	Tolls	Marketing	120.00	(120.00)	-	ADJ
43119	H. Aguilar	Marketing	Hospital	Marketing	156.96	(156.96)	-	ADJ
43131	A.McKaye	Memory Unit (	WH	Meetings/Wo	345.88	-	345.88	
43131	H.Reich-Aguila	Marketing	Hospital	Marketing	517.42	(517.42)	-	ADJ
43131	H. Aguilar	Marketing	Hospital	Marketing	28.34	(28.34)	-	ADJ
43131	H. Aguilar	Marketing	Hospital	Marketing	36.28	(36.28)	-	ADJ
43146	H.Reich-Aguila	Marketing	Hospital	Marketing	487.78	(487.78)	-	ADJ
43175	H. Aguilar	Marketing	Hospital	Marketing	548.82	(548.82)	-	ADJ
43189	H. Aguilar	Marketing	Hospital	Marketing	560.69	(560.69)	-	ADJ
43189	Y.Koolman			Case Mgmt	168.14	-	168.14	
43160		TCM	WH	Meetings/Wo	508.49	-	508.49	
43160		TCM	WH	Meetings/Wo	153.14	-	153.14	
43190	Alvin	TCM	WH	Meetings/Wo	36.28	-	36.28	
43190	Olivia	TCM	WH	Meetings/Wo	49.05	-	49.05	
43203	H. Aguilar	Marketing	Hospital	Marketing	552.09	(552.09)	-	ADJ
43203	K. Vasquez				48.40	-	48.40	
43217	H. Aguilar	Marketing	Hospital	Marketing	537.59	(537.59)	-	ADJ
43217	A.McKaye	Memory Unit (	WH	Meetings/Wo	669.97	-	669.97	
43220	Leadership Se	Leadership Se	minar Travle	Administratio	305.36	-	305.36	
43220	TCM	TCM	WH	Meetings/Wo	28.34	-	28.34	
43231	H. Aguilar	Marketing	Hospital	Marketing	488.32	(488.32)	-	ADJ
43245	H. Aguilar	Marketing	Hospital	Marketing	516.12	(516.12)	-	ADJ
43251	Olivia	TCM	WH	Meetings/Wo	27.25	-	27.25	
43251	Indeed Conf. T	TCM	Out of State		506.41	(506.41)	-	ADJ
43281	H. Aguilar	Marketing	Hospital	Marketing	469.79	(469.79)	-	ADJ
43259	H. Aguilar	Marketing	Hospital	Marketing	493.99	(493.99)	-	ADJ
43273	H. Aguilar	Marketing	Hospital	Marketing	541.95	(541.95)	-	ADJ
43281	Olivia	TCM	WH	Meetings/Wo	49.05	-	49.05	
43301	H. Aguilar	Marketing	Hospital	Marketing	274.14	(274.14)	-	ADJ
43312	H. Aguilar	Marketing	Hospital	Marketing	570.29	(570.29)	-	ADJ
43329	H.Aguilar	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43329	T.Kendzior				72.12	-	72.12	
43343	H. Aguilar	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43343	H. Aguilar	Marketing	Hospital	Marketing	40.00	(40.00)	-	ADJ
43357	Auto Allowanc	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43371	Auto Allowanc	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43371	Tolls	Marketing	Hospital	Marketing	80.00	(80.00)	-	ADJ
43385	Auto Allowanc	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43399	J. Prestel AHCA	Workshop			260.97	-	260.97	
43399	Heidi Auto All	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43413	H.Aguilar	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43427	H.Aguilar	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43434	TCM	TCM	WH	Meetings/Wo	49.05	-	49.05	
43455	T.Kendzior				74.47	-	74.47	
43455	Auto Allowanc	Marketing	Hospital	Marketing	**230.77**	(230.77)	-	ADJ
43441	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43463	Heidi Allowan	Marketing	Hospital	Marketing	230.77	(230.77)	-	ADJ
43465	Olivia	TCM	WH	Meetings/Wo	43.60	-	43.60	
43465	Olivia	TCM	WH	Meetings/Wo	49.05	-	49.05	
43465	Heidi Allowan	Marketing	Hospital	Marketing	32.97	(32.97)	-	ADJ
12/31/18	Olivia	TCM	WH	Meetings/Wo	49.05	-	49.05	
12/31/18	Mileage				6.40	-	6.40	
	Totals				**13,294.07**	**(10,138.42)**	**3,155.65**	

Winchester House
#0054049
Seminar Schedule
1/1/2018-12/31/2018

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
01/31/18	TCM	Advance Insights	Denise		IL	995.00	
01/31/18	TCM	Behavioral Interview Seminar	Terri Galloway		IL	72.50	
03/16/18	J Prestel	Mental Disorder	J. Prestel	Adminstrator	IL	81.00	
03/16/18	J. Koczwara	RAC-CT recert/Workshop	J. Koczwara		IL	180.00	
04/27/18	IL Pioneer Conf.	Various	Various	Administrative	IL	407.51	
5/31/18	TCM	Indeed Conference	Terri Galloway		Out of State	199.50	ADJ
09/03/18	CPI	Demetia Books			IL	528.36	
06/01/18	Pathway Health	Restorative/Rehab Cert	E. Morse	Rehab/Restortative	In House	1,299.00	
08/31/18	TCM	Phase 2 ROP Webinar			Online	55.00	
09/14/18	D. Kayler	ITOLA Conference			IL	265.00	
10/26/18	J. Prestel	AHCA Bronze Award Workshop	J. Prestel	Administrator	IL	25.00	
10/31/18	TCM	Moving Mountains Webinar	Various	Various	Online	27.50	
10/31/18	TCM	AHCA Webinar	Various	Various	Online	32.50	
11/09/18	D. Kayler	ST Assessment/SNG Significant Change	D. Kayler		IL	491.36	
12/31/18	TCM	Section Gg Webinar	Olivia Christiansen	TCM	***Online***	64.50	
						4,723.73	

Adjustments	(199.50)
ALLOCATED TC	6,267.00
Adjusted Total	10,791.23

Winchester House
#0054049
Legal Schedule
1/1/2018-12/31/2018

DATE	G/L ACCT. #	PAYEE/VENDOR	ADJ	AMOUNT	ADJ Amount	Adjusted Balance
1/31/2018	80550.00	Stone, McGuire & Seigel		758		758
1/31/2018	80550.00	Much Shellist		367		367
2/28/2018	80550.00	Stone, McGuire & Seigel		1,733		1,733
1/31/2018	80550.00	Much Shellist		2,504		2,504
2/28/2018	80550.00	Much Shellist		7,751		7,751
2/28/2018	80550.00	Much Shellist		339		339
3/31/2018	80550.00	Williams & Baerson, LLC		340		340
3/31/2018	80550.00	Stone, McGuire & Seigel	ADJ	1,655	(1,655)	-
5/31/2018	80550.00	Stone, McGuire & Seigel	ADJ	2,551	(2,551)	(0)
4/26/2018	80550.00	Much Shellist	ADJ	565	(565)	-
4/30/2018	80550.00	Much Shellist		1,469		1,469
5/1/2018	80550.00	Much Shellist		113		113
6/30/2018	80550.00	Much Shellist		170		170
6/30/2018	80550.00	Much Shellist		622		622
7/31/2018	80550.00	Much Shellist		339		339
7/31/2018	80550.00	Much Shellist		1,356		1,356
7/31/2018	80550.00	Much Shellist		226		226
8/31/2018	80550.00	Stone, McGuire & Seigel		1,015		1,015
8/31/2018	80550.00	Much Shellist		396		396
8/31/2018	80550.00	Much Shellist		113		113
9/30/2018	80550.00	Much Shellist		113		113
10/22/2018	80550.00	Nemmers		2,000		2,000
10/31/2018	80550.00	Much Shellist		226		226
4/1/2018	80550.00	Much Shellist	ADJ	9,923	(9,923)	-
11/4/2018	80550.00	Wilson, Elser, Moskowitz, Edleman & Dicker	ADJ	25,000	(25,000)	-
2/1/2018	80550.00	Much Shellist		593		593
4/1/2018	80550.00	Much Shellist		954		954
11/30/2018	80550.00	Much Shellist		622		622
12/31/2018	80550.00	Much Shellist		791		791
		Total		64,600	(39,694)	24,906

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $7865**

(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? **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? **5 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 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. $ **372,488**
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? **Yes** 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 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. $ **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 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? **Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **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