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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 1/1/2020 to 12/31/2020 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 326, Plainfield, IL 60544-0326
(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: 1/1/2020 Ending: 12/31/2020

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	31	Skilled (SNF)	31	11,346	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,508	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	409		3,552	3,961	8
9	SNF/PED					9
10	ICF	39,209	2,809		42,018	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,618	2,809	3,552	45,979	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.03%

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 2,815

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: 12/31/20 Fiscal Year: 12/31/20

* 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: 1/1/2020 Ending: 12/31/2020

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	304,960	43,361	14,014	362,335		362,335		362,335			1
2	Food Purchase		282,239		282,239		282,239		282,239			2
3	Housekeeping	215,188	72,391	54,060	341,639		341,639		341,639			3
4	Laundry	84,518	17,335		101,853		101,853		101,853			4
5	Heat and Other Utilities			186,446	186,446		186,446	981	187,427			5
6	Maintenance	63,213		57,811	121,024		121,024	1,412	122,436			6
7	Other (specify):* Waste Removal			19,233	19,233		19,233		19,233			7
8	TOTAL General Services	667,879	415,326	331,564	1,414,769		1,414,769	2,393	1,417,162			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,643,124	250,010	292,322	3,185,456		3,185,456	61,497	3,246,953			10
10a	Therapy	110,623		8,557	119,180		119,180	(8,557)	110,623			10a
11	Activities	78,709		3,529	82,238		82,238		82,238			11
12	Social Services	186,411		4,952	191,363		191,363		191,363			12
13	CNA Training											13
14	Program Transportation			10,585	10,585		10,585		10,585			14
15	Other (specify):* Mgmt Co Benefits Alloc							12,812	12,812			15
16	TOTAL Health Care and Programs	3,018,867	250,010	331,945	3,600,822		3,600,822	65,752	3,666,574			16
	C. General Administration											
17	Administrative	200,515		466,270	666,785		666,785	(399,511)	267,274			17
18	Directors Fees											18
19	Professional Services			298,173	298,173		298,173	13,521	311,694			19
20	Dues, Fees, Subscriptions & Promotions			25,481	25,481		25,481	6,640	32,121			20
21	Clerical & General Office Expenses	261,914	38,127	30,947	330,988		330,988	143,628	474,616			21
22	Employee Benefits & Payroll Taxes			456,319	456,319		456,319		456,319			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,270	1,270		1,270	211	1,481			24
25	Other Admin. Staff Transportation			3,481	3,481		3,481	1,859	5,340			25
26	Insurance-Prop.Liab.Malpractice			89,345	89,345		89,345	1,689	91,034			26
27	Other (specify):* Mgmt Co Benefits Alloc							40,284	40,284			27
28	TOTAL General Administration	462,429	38,127	1,371,286	1,871,842		1,871,842	(191,679)	1,680,163			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,149,175	703,463	2,034,795	6,887,433		6,887,433	(123,534)	6,763,899			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: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			64,295	64,295		64,295	197,109	261,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,884	55,884		55,884	1,377,964	1,433,848			32
33	Real Estate Taxes			90,000	90,000		90,000		90,000			33
34	Rent-Facility & Grounds			1,608,000	1,608,000		1,608,000	(1,589,750)	18,250			34
35	Rent-Equipment & Vehicles			34,455	34,455		34,455	1,875	36,330			35
36	Other (specify):* Loan Fees			83,333	83,333		83,333		83,333			36
37	**TOTAL Ownership**			1,935,967	1,935,967		1,935,967	(12,802)	1,923,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,620	358,894	409,514		409,514	(23,994)	385,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			352,444	352,444		352,444		352,444			42
43	Other (specify):* Disallowed Costs	70,799	5,003	259,667	335,469		335,469	(335,469)				43
44	**TOTAL Special Cost Centers**	70,799	55,623	971,005	1,097,427		1,097,427	(359,463)	737,964			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,219,974	759,086	4,941,767	9,920,827		9,920,827	(495,799)	9,425,028			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: 1/1/2020 Ending: 12/31/2020

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	(6,597)	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	(52,394)	30		9
10	Interest and Other Investment Income	(21,715)	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	(942)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(581)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(243,327)	43		24
25	Fund Raising, Advertising and Promotional	(13,804)	43		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	(60,611)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (399,971)		$	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)	(95,828)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (95,828)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (495,799)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Winfield Woods Hlthcare Ctr

ID# 0052100

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	$ (70,799)	43	1
2	Expense Repairs under $2,500	1,409	6	2
3	Expense Repairs under $2,500	8,779	21	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
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**	(60,611)		49

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	20	Licenses and Permits		Winfield Woods Realty	100.00%	$ 300	$ 300	1
2	V	30	Depreciation		Winfield Woods Realty	100.00%	249,382	249,382	2
3	V	32	Interest		Winfield Woods Realty	100.00%	1,393,446	1,393,446	3
4	V	34	Rent-Facility & Grounds	1,608,000	Winfield Woods Realty	100.00%		(1,608,000)	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			$ 1,608,000			$ 1,643,128	$ * 35,128	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 981	$ 981	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	3	3	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	61,497	61,497	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	12,812	12,812	18
19	V	17	Administrative	466,270	Premier Healthcare Management, LLC	100.00%	66,759	(399,511)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	9,460	9,460	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	257	257	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	134,266	134,266	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	211	211	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,548	1,548	24
25	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	100.00%	97	97	25
26	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	40,284	40,284	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	18,250	18,250	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	1,875	1,875	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			$ 466,270			$ 348,300	$ * (117,970)	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: 1/1/2020 Ending: 12/31/2020

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	$ 8,557	REX Therapeutics	100.00%	$	$ (8,557)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	4,642	4,642	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	6,083	6,083	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	583	583	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	311	311	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	1,592	1,592	20
21	V	30	Depreciation		REX Therapeutics	100.00%	121	121	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	6,233	6,233	22
23	V	39	Therapy Management Wages		REX Therapeutics	100.00%	12,122	12,122	23
24	V								24
25	V								25
26	V								26
27	V	39	Therapy Wages	331,540	REX Therapeutics	100.00%	267,592	(63,948)	27
28	V	39	Contract Therapy		REX Therapeutics	100.00%	0		28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	27,832	27,832	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			$ 340,097			$ 327,111	$ * (12,986)	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: 1/1/2020 Ending: 12/31/2020

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	2.90	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	2.90	Champaign Urbana Nursing and Rehab	Champaign	Management, LLC			2
3	Naomi Lopin	2.90	Pershing Gardens Healthcare Center	Stickney	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lopin	2.90	Gardenview Manor	Danville	Supplies, LLC			4
5	Michael & Carol Knopf	1.45	Norridge Gardens	Norridge	Winfield Woods	Winfield	Lessor	5
6	Isaac & Rachel Knopf	.72	Premier Healthcare of New Harmony, LLC	New Harmony, IN	Realty			6
7	Orsheve Enterprises	5.09			REX Therapeutics	Skokie	Therapy	7
8	Shalom Zupnik	1.45						8
9	Barak Baver	79.69						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	5.77	14.43	Alloc Salary	$ 6,377	21-7	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	$ 6,377		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	Operating Revenues	64,636,666	8	$ 6,803	$	9,325,391	$ 981	1
2	6	Maintenance	Operating Revenues	64,636,666	8	20		9,325,391	3	2
3	10	Nursing and Medical Records	Operating Revenues	64,636,666	8	426,253	426,253	9,325,391	61,497	3
4	15	Emp Benefit Alloc-Healthcare	Operating Revenues	64,636,666	8	88,802		9,325,391	12,812	4
5	17	Administrative	Operating Revenues	64,636,666	8	462,726	462,726	9,325,391	66,759	5
6	19	Professional Services	Operating Revenues	64,636,666	8	65,562		9,325,391	9,460	6
7	20	Dues, Fees, Subs & Promo	Operating Revenues	64,636,666	8	1,782		9,325,391	257	7
8	21	Clerical & Gen Office Expenses	Operating Revenues	64,636,666	8	930,635	877,535	9,325,391	134,266	8
9	24	Travel and Seminar	Operating Revenues	64,636,666	8	1,464		9,325,391	211	9
10	25	Other Admin. Staff Trans	Operating Revenues	64,636,666	8	10,729		9,325,391	1,548	10
11	26	Insurance-Prop.Liab.Malpractice	Operating Revenues	64,636,666	8	675		9,325,391	97	11
12	27	Emp Benefit Alloc-Gen Admin	Operating Revenues	64,636,666	8	279,218		9,325,391	40,284	12
13	34	Rent-Facility & Grounds	Operating Revenues	64,636,666	8	126,494		9,325,391	18,250	13
14	35	Equipment Rental	Operating Revenues	64,636,666	8	12,997		9,325,391	1,875	14
15										15
16	17	Professional Services	Direct Allocation	60,000	1	60,000			0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,474,160	$ 1,766,514		$ 348,300	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	8,309,425	12	$ 112,512	$	342,830	$ 4,642	1
2	20	Fees and Subscriptions	Therapy Revenue	8,309,425	12	147,440		342,830	6,083	2
3	21	Clerical & General Office Exp	Therapy Revenue	8,309,425	12	14,128		342,830	583	3
4	25	Other Admin Staff Transp	Therapy Revenue	8,309,425	12	7,522		342,830	311	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	8,309,425	12	38,581		342,830	1,592	5
6	30	Depreciation	Therapy Revenue	8,309,425	12	2,921		342,830	121	6
7	32	Interest Expense	Therapy Revenue	8,309,425	12	151,084		342,830	6,233	7
8	39	Therapy Management Wages	Therapy Revenue	8,309,425	12	293,802	293,802	342,830	12,122	8
9										9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	5,717,814	12	5,424,012	5,424,012	267,592	267,592	12
13	39	Contract Therapy	Direct Allocation	206,555	3	206,555				13
14	39	Allocated Employee Benefits	Total Wages	5,717,814	12	569,187		279,714	27,832	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,967,744	$ 5,717,814		$ 327,111	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	12,723,832	5/31/2021	0.0350	1,091,152	1
2	Bank Leumi		X	Mortgage	$6,130.00	5/31/2016	3,520,000	3,170,140	5/31/2021	0.0350	302,294	2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,146,632			51,723	6
7	TCF		X	Bus	$1,241.20	11/23/19	63,209	51,234			4,161	7
8												8
9	TOTAL Facility Related				$29,091.20		$ 16,063,209	$ 17,091,838			$ 1,449,330	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			6,233	11
12								Offset Interest Income			(21,715)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15,482)	14
15	TOTALS (line 9+line14)						$ 16,063,209	$ 17,091,838			$ 1,433,848	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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 82,668	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.)	2019	$ 84,268	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,600	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 88,400	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.		$ 90,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	76,432	8
	2016	77,477	9
	2017	79,563	10
	2018	81,356	11
	2019	84,268	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 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 2019 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 2019.

	(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	$ 84,267.78	$ 84,267.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 84,267.78	$ 84,267.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,845 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (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 [X] (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: 1/1/2020 Ending: 12/31/2020

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	$ 754,284	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	3,655	9
10	5 New Wall Outlets: 3 On Second Floor, 2 On First Floor			2013	2,800		20	140	140	1,038	10
11	Electric Installation Of Emergency Outlets			2013	30,100		20	1,505	1,505	8,882	11
12	Landscaping			2014	3,400		20	170	170	946	12
13	Elevator Door Repair			2014	3,750		20	188	188	1,038	13
14	Rooftop Replacement			2014	11,268		20	563	563	3,057	14
15	Replace Water Heater/Pipes/Valves For Kitchen/Laundry Room			2015	7,749		20	387	387	2,322	15
16	Installation Of Electrical Sources/Wiring In Mechanical Room			2015	6,455		20	323	323	1,938	16
17	Rebuilding Of Chimney/Tuckpointing			2015	8,700		20	435	435	2,610	17
18	Instal Of New Heat Exchanger/New Burners/Rollout Switch			2015	7,438		20	372	372	2,232	18
19	Wanderguard Id/Wall Mounts/Signaling Device/Magnetic Locks			2015	29,745		20	1,487	1,487	8,922	19
20	Install Roam Alert System/Door Controller/Electrical			2015	31,619		20	1,581	1,581	9,486	20
21	Install Roam Alert Eco Door Control/Excitor Antenna/Annunciator			2015	21,705		20	1,085	1,085	6,510	21
22	Generator			2015	3,136		20	157	157	1,256	22
23	Generator			2015	3,136		20	157	157	1,256	23
24	Installed New Motor, Housing and Backplate at RTU #1			2016	2,529		20	126	126	567	24
25	Installed 16 New Smoke/Fire Damper Motors			2016	8,221		20	411	411	1,850	25
26	Clean, Patch, Seal and Stripe Parking Lot			2016	5,700		20	285	285	1,283	26
27	Re-pipe Generator Feed			2016	3,428		20	171	171	770	27
28	Parking Lot Repaving			2016	5,352		20	268	268	1,206	28
29	Install 9 Door Alarms and Nursing Station Annunciators			2016	6,295		20	315	315	1,417	29
30	Install Emergency Call System			2016	18,600		20	930	930	4,185	30
31	Elevator Repairs-Replaced Micro-chip, Adjust Rollers, Rebuilt Starter			2016	3,157		20	158	158	711	31
32	Repairs/Maintenance on HVAC Units			2017	8,015		20	401	401	1,403	32
33	Install Electric Booster Heater			2017	3,435		20	172	172	602	33
34	Replace Compressor in HVAC Unit			2017	4,357		20	218	218	763	34
35	Install Rheem 7.5 Ton Furnace			2018	12,800		20	640	640	1,600	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Elevator Repair	2018	$ 3,660	$	20	$ 183	$ 183	$ 366	37
38	HVAC/Ductwork Repairs	2019	17,373		20	869	869	1,303	38
39	Repair Main Entrance Handicap Door	2019	2,515		20	126	126	189	39
40	Electrical Repair	2019	3,091		20	155	155	232	40
41	Bathroom Plumbing Repair	2019	3,188		20	159	159	239	41
42	Replace Air Conditioner	2019	24,890		20	1,245	1,245	1,867	42
43	Sealcoat/Striping/Patching Parking Lot	2019	8,442		20	422	422	633	43
44	Replaced Fire Dampers	2020	9,490		20	237	237	237	44
45	Remove Old and Replace with Industrial Drain and Cover	2020	5,000		20	125	125	125	45
46	Addition to Emergency Generator Systems	2020	7,225		20	181	181	181	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	Allocated from Premier Healthcare Management, LLC	2013	3,592		20	179	179	1,112	56
57									57
58									58
59	Allocated from REX Therapeutics					121	121		59
60									60
61									61
62	Financial Statement Depreciation			28,568			(28,568)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,745,072	$ 28,568		$ 142,547	$ 113,979	$ 832,273	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: 1/1/2020 Ending: 12/31/2020

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	$ 1,023,764	$ 22,551	$ 102,377	$ 79,826	10 yrs	$ 642,986	71
72	Current Year Purchases	38,376	4,146	3,838	(308)	10 yrs	3,838	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,062,140	$ 26,697	$ 106,215	$ 79,518		$ 646,824	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	Resident	2020 Ford Elkhart Coach ECII	2019	$ 63,209	$ 9,030	$ 12,642	$ 3,612	5	$ 18,963	76
77										77
78										78
79										79
80	TOTALS			$ 63,209	$ 9,030	$ 12,642	$ 3,612		$ 18,963	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)	$ 6,330,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 64,295	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 261,404	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 197,109	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,498,060	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	N/A	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				18,250			5
6								6
7	TOTAL				$ 18,250 **			7

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.	/2021	$
13.	/2022	$
14.	/2023	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: $ 34,455 Description: See Attached Schedule 14A
(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	Allocated from Management Co			1,875	19
20					20
21	TOTAL		$	$ 1,875	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: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	27,388
Office Equipment	7,067
Total - Line 16	**34,455**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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)	3045 hrs	$ 94,474		$	$	3,045	$ 94,474	1
2	Licensed Speech and Language Development Therapist	39(7)	1560 hrs	48,399				1,560	48,399	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(7)	4020 hrs	124,719				4,020	124,719	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				50,481		50,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy Management	39(7)	86	12,122				86	12,122	12
13	Other (specify): See Attached Sch 16A	39(3)				27,493			27,493	13
14	TOTAL			$ 279,714		$ 27,493	$ 50,481	8,711	$ 357,688	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: **12/31/2020**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	27,354
Outside MD Service-MCA	39(3)	139
Total - Line 13		**27,493**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,143,820	$ 1,219,909	1
2	Cash-Patient Deposits	3,007	3,007	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,478,666	1,478,666	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,958	2,958	6
7	Other Prepaid Expenses	181,603	511,603	7
8	Accounts Receivable (owners or related parties)	376,396	4,735,628	8
9	Other(specify): Employee Loans	1,841	1,841	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,188,291	$ 7,953,612	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	296,542	345,072	15
16	Equipment, at Historical Cost	503,777	1,125,349	16
17	Accumulated Depreciation (book methods)	(486,762)	(1,498,060)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Costs	7,715	48,155	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 321,272	$ 4,880,516	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,509,563	$ 12,834,128	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 938,959	$ 938,959	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,552	4,552	28
29	Short-Term Notes Payable	1,197,866	4,368,006	29
30	Accrued Salaries Payable	517,531	517,531	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,692	12,692	31
32	Accrued Real Estate Taxes(Sch.IX-B)		88,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	424,223	424,223	36
37	Due to Related Parties			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,095,823	$ 6,354,363	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,723,832	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)**	$	$ 12,723,832	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,095,823	$ 19,078,195	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 413,740	$ (6,244,067)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,509,563	$ 12,834,128	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Winfield Woods Hlthcare Ctr**
IDPH License ID Number: **0052100**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to HFS	50,413	50,413
Due to Medicare	344,590	344,590
Security Deposits	29,220	29,220
Total - Line 36	**424,223**	**424,223**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (866,225)	1
2	Restatements (describe):		2
3	**Post closing adjustments -Bad Debts**	(122,208)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (988,433)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,402,173	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,402,173	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)**	$ 413,740	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: 1/1/2020 Ending: 12/31/2020

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	$ 8,507,825	1
2	Discounts and Allowances for all Levels	685,507	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,193,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	132,096	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 132,096	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,975,894	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)**	$ 1,975,857	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,715	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,715	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,323,000	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,414,769	31
32	Health Care	3,600,822	32
33	General Administration	1,871,842	33
	B. Capital Expense		
34	Ownership	1,935,967	34
	C. Ancillary Expense		
35	Special Cost Centers	744,983	35
36	Provider Participation Fee	352,444	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,920,827	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,402,173	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,402,173	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,367,453	44
45	Private Pay - Net Inpatient Revenue	552,115	45
46	Medicare - Net Inpatient Revenue	1,672,559	46
47	Other-(specify) Insurance	424,548	47
48	Other-(specify) Hospice	176,657	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,193,332	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: 1/1/2020 Ending: 12/31/2020

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	1,713	1,913	$ 86,315	$ 45.12	1
2	Assistant Director of Nursing	1,052	1,180	54,677	46.34	2
3	Registered Nurses	16,302	17,540	671,390	38.28	3
4	Licensed Practical Nurses	14,784	16,131	484,001	30.00	4
5	CNAs & Orderlies	46,957	52,315	1,204,381	23.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,939	6,439	110,623	17.18	8
9	Activity Director					9
10	Activity Assistants	4,472	4,947	78,709	15.91	10
11	Social Service Workers	7,671	8,513	186,411	21.90	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,095	59,077	28.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,307	15,324	245,883	16.05	15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,247	63,213	28.13	17
18	Housekeepers	15,612	17,753	215,188	12.12	18
19	Laundry	5,599	6,135	84,518	13.78	19
20	Administrator	1,858	2,000	153,048	76.52	20
21	Assistant Administrator	848	967	47,467	49.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,095	11,372	261,914	23.03	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	1,976	2,039	34,811	17.07	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	3,065	3,171	178,348	56.24	33
34	TOTAL (lines 1 - 33)	156,149	172,081	$ 4,219,974 *	$ 24.52	34

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	$ 14,014	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,297	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	73	4,894	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	73	$ 41,205		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,642	$ 205,477	L10, C3	50
51	Licensed Practical Nurses	1,178	67,667	L10, C3	51
52	Certified Nurse Assistants/Aides	343	8,881	L10, C3	52
53	TOTAL (lines 50 - 52)	4,163	$ 282,025		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Winfield Woods Hlthcare Ctr

Period Beginning **1/1/2020**
Period End **12/31/2020**

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		1,257	1,283	107,549	83.83
Marketing		1,808	1,888	70,799	37.50
	TOTAL	3,065	3,171	178,348	

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nora O'Gorman	Administrator	0	$ 32,253
Ma Maivette Gleeson	Administrator	0	120,795
Kristen Hendricks	Asst Administrator	0	47,467
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,515

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 466,270
TOTAL (agree to Schedule V, line 17, col. 3)	$ 466,270
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 111,685
Wipfli LLP	Accounting	8,208
CohnReznick LLP	Accounting	16,700
Richard Peelo & Associates, Inc.	Accounting	2,800
Plante & Moran, PLLC	Accounting	112
Personnel Planners	Unemployment Consultant	396
Lofgren, Sharon	Medicare Billing	3,600
M&M Financial	Financial Consultant	750
Bill.Com	Bill Payment Processing	2,741
See Attached Schedule 21A		151,181
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 298,173

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	24,586
FICA Taxes	304,084
Employee Health Insurance	113,549
Employee Meals	3,429
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	10,671
TOTAL (agree to Schedule V, line 22, col.8)	$ 456,319

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 829
Advertising: Employee Recruitment	10,442
Health Care Worker Background Check	
(Indicate # of checks performed)	4,182
Patient Background Checks	40
Dues & Subscriptions	4,151
Licenses & Permits	1,763
Allscripts	4,074
Allocated from REX Therapeutics	6,083
Allocated from Mgmt Co./RE Entity	557
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,121

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,270
Allocated from Management Co.	211
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,481

* 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: **12/31/2020**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Resolute Healthcare Solutions	Healthcare Billing	15,347
Terrill Consulting Services, Inc.	Billing Consultant	31,440
GCHMO, Inc.	Managed Care Contracting Services	14,850
Collaborative Healthcare Urgency Grou	Healthcare Emergency Preparedness	1,000
Dyatech, LLC	Benefits Consulting	338
InPath Security	Data Processing	22,788
HDSI	Data Processing	1,900
Change Healthcare	Data Processing	696
eSolutions, Inc	Data Processing	3,891
Paycor	Payroll Processing	16,596
Matrixcare	Data Processing	35,670
Experian Health, Inc.	Revenue Cycle Management	288
ABILITY Network Inc.	Data Processing	4,758
TaxSaver Plan	Benefits Administration	469
TriageNow LLC	Work Comp Consultant	450
Sedgwick CMS	Claims Management	700
Total		**151,181**

Facility Name & ID Number Winfield Woods Hlthcare Ctr # 0052100 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,338** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **352,444**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,429** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 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.