

Facility Name & ID Number Winfield Healthcare Center

0052100 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>31</u>	Skilled (SNF)	<u>31</u>	<u>11,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>107</u>	Intermediate (ICF)	<u>107</u>	<u>39,055</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>138</u>	TOTALS	<u>138</u>	<u>50,370</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>3,076</u>	<u>3,076</u>	8
9	SNF/PED					9
10	ICF	<u>41,753</u>	<u>1,738</u>	<u>73</u>	<u>43,564</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,753</u>	<u>1,738</u>	<u>3,149</u>	<u>46,640</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.59%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

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 Date 10/29/2012 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 3,076

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Winfield Healthcare Center # 0052100 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	206,420	24,692	13,701	244,813		244,813		244,813		1
2	Food Purchase		282,891		282,891		282,891	(1,105)	281,786		2
3	Housekeeping	173,170	34,949		208,119		208,119		208,119		3
4	Laundry	65,412	3,171		68,583		68,583		68,583		4
5	Heat and Other Utilities			167,324	167,324		167,324	771	168,095		5
6	Maintenance	32,702		84,690	117,392		117,392	27,409	144,801		6
7	Other (specify):*										7
8	TOTAL General Services	477,704	345,703	265,715	1,089,122		1,089,122	27,075	1,116,197		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,583,230	102,701	22,804	1,708,735		1,708,735	48,501	1,757,236		10
10a	Therapy	148,971		18,000	166,971		166,971		166,971		10a
11	Activities	94,039	4,054		98,093		98,093		98,093		11
12	Social Services	195,303		2,226	197,529		197,529		197,529		12
13	CNA Training										13
14	Program Transportation			1,479	1,479		1,479		1,479		14
15	Other (specify):*							9,066	9,066		15
16	TOTAL Health Care and Programs	2,021,543	106,755	65,509	2,193,807		2,193,807	57,567	2,251,374		16
	C. General Administration										
17	Administrative	111,500		380,462	491,962		491,962	(225,737)	266,225		17
18	Directors Fees										18
19	Professional Services			116,121	116,121		116,121	(16,295)	99,826		19
20	Dues, Fees, Subscriptions & Promotions			37,868	37,868		37,868	(21,282)	16,586		20
21	Clerical & General Office Expenses	116,369	21,514	195,592	333,475		333,475	(77,097)	256,378		21
22	Employee Benefits & Payroll Taxes			413,055	413,055		413,055		413,055		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,164	13,164		13,164	76	13,240		24
25	Other Admin. Staff Transportation			5,577	5,577		5,577		5,577		25
26	Insurance-Prop.Liab.Malpractice			44,238	44,238		44,238	710	44,948		26
27	Other (specify):*							39,854	39,854		27
28	TOTAL General Administration	227,869	21,514	1,206,077	1,455,460		1,455,460	(299,771)	1,155,689		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,727,116	473,972	1,537,301	4,738,389		4,738,389	(215,130)	4,523,259		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

Winfield Healthcare Center

#0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,000	18,000		18,000	231,150	249,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,981	3,981		3,981	365,157	369,138			32
33	Real Estate Taxes			73,503	73,503		73,503		73,503			33
34	Rent-Facility & Grounds			598,498	598,498		598,498	(580,117)	18,381			34
35	Rent-Equipment & Vehicles			19,529	19,529		19,529		19,529			35
36	Other (specify):*			1,200	1,200		1,200	(1,200)				36
37	TOTAL Ownership			714,711	714,711		714,711	14,990	729,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,143	345,978	542,121		542,121		542,121			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			339,988	339,988		339,988		339,988			42
43	Other (specify):*	15,922	2,412	30,327	48,661		48,661	(48,660)	1			43
44	TOTAL Special Cost Centers	15,922	198,555	716,293	930,770		930,770	(48,660)	882,110			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,743,038	672,527	2,968,305	6,383,870		6,383,870	(248,799)	6,135,071			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 Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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	230,417	30		9
10	Interest and Other Investment Income	(152)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(105)	02		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	(30,417)	21		18
19	Entertainment				19
20	Contributions	(21,900)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(68,462)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 19,381		\$	30

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	2	
		Amount	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)	(268,180)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (268,180)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (248,799)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY

48		49		50		51		52	
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Winfield Healthcare Center

ID# 0052100

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Comissions	\$ (1,000)	02	1
2	Rental Income	(100)	06	2
3	Marketing Salary	(15,922)	43	3
4	Marketing Expenses	(32,738)	43	4
5	Bank Charges	(43,035)	21	5
6	Trust Fees	(800)	21	6
7	Amortization - Organization Expense	(1,200)	36	7
8	Capitalized R&M	(3,913)	06	8
9	Additional R&M	30,897	06	9
10	PAC Dues	(651)	20	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	(68,462)		49

Winfield Healthcare Center

Report Period Beginning: ID# 0052100
 Ending: 01/01/15
 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winfield Healthcare Center# 0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,105)											(1,105)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			771									771	5
6	Maintenance	26,884		525									27,409	6
7	Other (specify):*													7
8	TOTAL General Services	25,779		1,296									27,075	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			52,414	(3,913)								48,501	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			9,066									9,066	15
16	TOTAL Health Care and Programs			61,480	(3,913)								57,567	16
	C. General Administration													
17	Administrative			(225,737)									(225,737)	17
18	Directors Fees													18
19	Professional Services			(16,295)									(16,295)	19
20	Fees, Subscriptions & Promotions	(22,551)		1,269									(21,282)	20
21	Clerical & General Office Expenses	(164,252)		87,155									(77,097)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			76									76	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			710									710	26
27	Other (specify):*			39,854									39,854	27
28	TOTAL General Administration	(186,803)		(112,968)									(299,771)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(161,024)		(50,192)	(3,913)								(215,130)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winfield Healthcare Center# 0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	230,417		733									231,150	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(152)	365,309										365,157	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(598,498)	18,381									(580,117)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(1,200)											(1,200)	36
37	TOTAL Ownership	229,065	(233,189)	19,114									14,990	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(48,660)											(48,660)	43
44	TOTAL Special Cost Centers	(48,660)											(48,660)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	19,381	(233,189)	(31,078)	(3,913)								(248,799)	45

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 598,498	Winfield Woods Realty	100.00%	\$	(598,498)	1
2	V	32 Interest Expense		Winfield Woods Realty	100.00%	365,309	365,309	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 598,498			\$ 365,309	\$ * (233,189)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	\$ 771	\$	771	15
16	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	525		525	16
17	V	10 NURSING SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	52,414		52,414	17
18	V	15 EMPLOYEE BEN. HEALTH CARE.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	9,066		9,066	18
19	V	17 NON-OWNER ADMIN. COMP.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	105,067		105,067	19
20	V	17 SALARY - DAVID CHEPLOWITZ		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	24,829		24,829	20
21	V	17 SALARY - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	24,829		24,829	21
22	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	3,705		3,705	22
23	V	20 LICENSES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,269		1,269	23
24	V	21 OFFICE EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	79,924		79,924	24
25	V	24 SEMINARS		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	76		76	25
26	V	26 AUTO EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	710		710	26
27	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	38,596		38,596	27
28	V	30 DEPRECIATION		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	733		733	28
29	V	34 RENT		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	18,381		18,381	29
30	V								30
31	V								31
32	V								32
33	V	21 CLERICAL SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	7,231		7,231	33
34	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,258		1,258	34
35	V								35
36	V	17 MANAGEMENT FEES	380,462	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%			(380,462)	36
37	V	19 CONSULTING SERVICES	20,000					(20,000)	37
38	V								38
39	Total		\$ 400,462			\$ 369,384	\$ *	(31,078)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 MEDICAL SUPPLIES	\$ 7,420	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	\$ 3,507	\$ (3,913)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,420			\$ 3,507	\$ * (3,913)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Winfield Healthcare Center

#

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	David Cheplowitz	Shareholder	Administrative	37.6810%	See Attached	7.00	17.50%	Mgmt Fee	\$ 24,830	17-7	1	
2	Barak Bayer	Shareholder	Administrative	37.6810%	See Attached	7.00	17.50%	Mgmt Fee	24,829	17-7	2	
3	Sara Bayer	Relative	Clerical	0.00%	See Attached	7.00	17.50%	Alloc. Salary	7,231	21-7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 56,890		13	

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

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PREMIER HEALTHCARE MANAGEMENT, L
 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	307,887	7	\$ 5,092	\$ 46,640	\$ 771	1
2	6	REPAIRS AND MAINTENANC	PATIENT DAYS	307,887	7	3,468	46,640	525	2
3	10	NURSING SALARY	PATIENT DAYS	307,887	7	346,005	346,005	46,640	52,414
4	15	EMPLOYEE BEN. HEALTH CA	PATIENT DAYS	307,887	7	59,847	46,640	9,066	4
5	17	NON-OWNER ADMIN. COM	PATIENT DAYS	307,887	7	693,582	693,582	46,640	105,067
6	17	SALARY - DAVID CHEPLOWI	PATIENT DAYS	307,887	7	163,907	163,907	46,640	24,829
7	17	SALARY - BARAK BAVER	PATIENT DAYS	307,887	7	163,907	163,907	46,640	24,829
8	19	PROFESSIONAL FEES	PATIENT DAYS	307,887	7	24,461	46,640	3,705	8
9	20	LICENSES	PATIENT DAYS	307,887	7	8,375	46,640	1,269	9
10	21	OFFICE EXPENSE	PATIENT DAYS	307,887	7	527,609	459,690	46,640	79,924
11	24	SEMINARS	PATIENT DAYS	307,887	7	501	46,640	76	11
12	26	AUTO EXPENSE	PATIENT DAYS	307,887	7	4,685	46,640	710	12
13	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	307,887	7	254,783	46,640	38,596	13
14	30	DEPRECIATION	PATIENT DAYS	307,887	7	4,840	46,640	733	14
15	34	RENT	PATIENT DAYS	307,887	7	121,336	46,640	18,381	15
16									16
17									17
18									18
19	21	CLERICAL SALARY	PATIENT DAYS	40	6	41,318	41,318	7	7,231
20	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	40	6	7,190	7	1,258	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,430,906	\$ 1,868,409	\$ 369,384	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

PREMIER HEALTHCARE SUPPLIES, LLC

Street Address

8170 N. MCCORMICK BLVD. SUITE 137

City / State / Zip Code

SKOKIE, IL 60076

Phone Number

(847) 674-2800

Fax Number

(847) 674-4133

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	REVENUE	113,303	7	\$ 53,554	\$ 12,454	\$ 3,507	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 53,554	\$	\$ 3,507	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										
										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	MB Financial		X	Mortgage			\$	\$ 7,659,525		\$ 365,309	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	MB Financial		X	Note Payable				175,452		3,981	6								
7											7								
8											8								
9	TOTAL Facility Related						\$	\$ 7,834,977		\$ 369,290	9								
B. Non-Facility Related*																			
10	Interest Income		X							(152)	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (152)	14								
15	TOTALS (line 9+line14)						\$	\$ 7,834,977		\$ 369,138	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.)

** 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 Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

* 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' COMPILATION 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 Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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. (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2015</u>	<u>\$ 460,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 460,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	138		2015	1971	\$ 4,400,000	\$	35	\$ 125,714	\$ 125,714	\$ 125,714	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		3,770	34		188	154	414	68
69			18,000			(18,000)		69
70		\$ 4,403,770	\$ 18,034		\$ 125,902	\$ 107,868	\$ 126,128	70

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

Facility Name & ID Number Winfield Healthcare Center

0052100

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,403,770	\$ 18,034		\$ 125,902	\$ 107,868	\$ 126,128	1
2	Rci Delayed Egress Mag Lock With Internal Sounder	2013	3,716		20	743	743	2,168	2
3	5 New Wall Outlets: 3 On Second Floor, 2 On First Floor	2013	2,800		20	140	140	338	3
4	Electric Installation Of Emergency Outlets	2013	30,100		20	772	772	2,090	4
5	Landscaping	2014	3,400		20	97	97	170	5
6	Elevator Door Repair	2014	3,750		20	107	107	179	6
7	Rooftop Replacement	2014	11,268		20	322	322	483	7
8	Replace Water Heater/Pipes/Valves For Kitchen/Laundry Room	2015	7,749		20	387	387	387	8
9	Installation Of Electrical Sources/Wiring In Mechanical Room	2015	6,455		20	323	323	323	9
10	Rebuilding Of Chimney/Tuckpointing	2015	8,700		20	435	435	435	10
11	Instal Of New Heat Exchanger/New Burners/Rollout Switch	2015	7,438		20	372	372	372	11
12	Wanderguard Id/Wall Mounts/Signaling Device/Magnetic Locks	2015	29,745		20	1,487	1,487	1,487	12
13	Install Roam Alert System/Door Controller/Electrical	2015	31,619		20	1,581	1,581	1,581	13
14	Install Roam Alert Eco Door Control/Excitor Antenna/Annunciato	2015	21,705		20	1,085	1,085	1,085	14
15	Generator	2015	3,136		20	314	314	314	15
16	Generator	2015	3,136		20	314	314	314	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	TOTAL (lines 1 thru 33)		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	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
31								31
32								32
33								33
34		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	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
31								31
32								32
33								33
34		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	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
31								31
32								32
33								33
34		\$ 4,578,486	\$ 18,034		\$ 134,381	\$ 116,347	\$ 137,853	34

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

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	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

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	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier HC Management	2013	3,770	34	20	188	154	414	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	TOTAL (lines 1 thru 33)		\$ 3,770	\$ 34		\$ 188	\$ 154	\$ 414	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,770	\$ 34		\$ 188	\$ 154	\$ 414	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,770	\$ 34		\$ 188	\$ 154	\$ 414	34

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

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 172,503	\$ 282	\$ 37,014	\$ 36,732	10	\$ 64,809	71
72	Current Year Purchases	777,952	418	77,756	77,338	10	77,756	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 950,455	\$ 700	\$ 114,770	\$ 114,070		\$ 142,565	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)	\$ 5,988,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,734	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,151	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 230,417	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 280,418	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Premier HC Mgmt, LLC				18,381			5
6								6
7	TOTAL				\$ 18,381			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: _____ *

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: \$ 228 Description: See Attached Schedule

(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	Facility	Lexus	\$ 1,608.45	\$ 19,301	17
18					18
19					19
20					20
21	TOTAL		\$ 1,608.45	\$ 19,301	21

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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 99,231	\$		\$ 99,231	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,274			1,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			245,473			245,473	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				174,093		174,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						22,050		22,050	13
14	TOTAL			\$		\$ 345,978	\$ 196,143		\$ 542,121	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.

Facility Name & ID Number Winfield Healthcare Center# 0052100Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 938,499	\$ 1,085,796	1
2	Cash-Patient Deposits	341,412	341,412	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,617,884	2,617,884	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,300	96,300	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		100,527	8
9	Other(specify):	1,299,324	1,328,137	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,293,419	\$ 5,570,056	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	153,197	153,197	15
16	Equipment, at Historical Cost	303,957	1,043,957	16
17	Accumulated Depreciation (book methods)	(75,050)	(75,050)	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):	765,990	2,818,567	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,148,094	\$ 8,800,671	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,441,513	\$ 14,370,727	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,718,014	\$ 2,684,376	26
27	Officer's Accounts Payable	488,500	488,500	27
28	Accounts Payable-Patient Deposits	187,842	187,842	28
29	Short-Term Notes Payable	175,452	175,452	29
30	Accrued Salaries Payable	95,920	95,920	30
31	Accrued Taxes Payable (excluding real estate taxes)	225,722	225,722	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,775	91,024	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	368,436	368,436	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,264,661	\$ 4,317,272	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,659,525	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	17,481	17,481	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,481	\$ 7,677,006	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,282,142	\$ 11,994,278	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,159,371	\$ 2,376,449	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,441,513	\$ 14,370,727	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,233,507	1
2	Restatements (describe):		2
3	Equity Restatement	(208,561)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,024,946	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,171,175	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	(36,750)	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)	\$ 1,134,425	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,159,371	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning: 01/01/15

Ending:

12/31/15

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,902,396	1
2	Discounts and Allowances for all Levels	573,355	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,475,751	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	78,042	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 78,042	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	100	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	152	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 152	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,555,045	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,089,122	31
32	Health Care	2,193,807	32
33	General Administration	1,455,460	33
B. Capital Expense			
34	Ownership	714,711	34
C. Ancillary Expense			
35	Special Cost Centers	590,782	35
36	Provider Participation Fee	339,988	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,383,870	40
41	Income before Income Taxes (line 30 minus line 40)**	1,171,175	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,171,175	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,447,189	44
45	Private Pay - Net Inpatient Revenue	284,833	45
46	Medicare - Net Inpatient Revenue	1,672,499	46
47	Other-(specify) <u>Insurance</u>	71,230	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,475,751	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.

Facility Name & ID Number **Winfield Healthcare Center**

0052100

Report Period Beginning: **01/01/15**

Ending:

12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,527	1,840	\$ 90,640	\$ 49.26	1
2	Assistant Director of Nursing	538	584	23,214	39.75	2
3	Registered Nurses	14,997	17,042	505,014	29.63	3
4	Licensed Practical Nurses	13,737	14,614	368,573	25.22	4
5	CNAs & Orderlies	42,278	45,461	561,080	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,298	11,837	148,971	12.59	8
9	Activity Director	1,913	2,102	41,199	19.60	9
10	Activity Assistants	3,869	4,299	52,840	12.29	10
11	Social Service Workers	8,734	9,494	195,303	20.57	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,311	46,243	20.01	13
14	Head Cook	5,721	6,357	73,038	11.49	14
15	Cook Helpers/Assistants	7,505	8,339	87,139	10.45	15
16	Dishwashers					16
17	Maintenance Workers	2,017	2,318	32,702	14.11	17
18	Housekeepers	17,823	19,372	173,170	8.94	18
19	Laundry	6,110	6,789	65,412	9.63	19
20	Administrator	2,185	2,350	111,500	47.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,952	5,826	116,369	19.97	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	1,828	2,031	34,709	17.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	649	662	15,922	24.05	33
34	TOTAL (lines 1 - 33)	148,761	163,628	\$ 2,743,038 *	\$ 16.76	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 13,701	01-03	35
36	Medical Director	Monthly	21,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	400	10-03	38
39	Pharmacist Consultant	Monthly	14,975	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,226	12-03	45
46	Other(specify)				46
47	Rehab Consultant	Monthly	18,000	10A-03	47
48	MDS Consultant	Monthly	7,429	10-03	48
49	TOTAL (lines 35 - 48)		\$ 77,731		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nora O'Gorman	Administrator	0.00	\$ 53,520	Workers' Compensation Insurance	\$ 41,115	IDPH License Fee	\$ 1,990	
Deanna Dang	Administrator	0.00	57,980	Unemployment Compensation Insurance	61,092	Advertising: Employee Recruitment	7,231	
				FICA Taxes	204,563	Health Care Worker Background Check		
				Employee Health Insurance	96,808	(Indicate # of checks performed 69)	692	
				Employee Meals		Patient Background Checks	102 1,019	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,522	
				Other Employee Benefits	9,477	Licenses & Permits	1,863	
						Allocated from Premier HC Mgmt, LLC	1,269	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 111,500					
B. Administrative - Other								
Description			Amount					
Management Fees - Premier Healthcare Management			\$ 380,462					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 380,462					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
FR&R/Marcum LLP	Accounting		\$ 31,692				Out-of-State Travel	\$
See Attached	Legal		21,041					
E-Health Data Solutions	Data Processing		5,979					
Premier Healthcare Mgmt	Consulting		20,000				In-State Travel	
Sharon Lofgren	Consulting		3,600					
Personnel Planners	Unemployment Consulting		1,906					
Blymas Inc	Consulting		720					
ADP	Payroll Processing		3,872				Seminar Expense	13,164
HDSI	A/R Accounting Services		5,735				Allocated from Premier HC Mgmt, LLC	76
Singer Networks LLC	Data Processing		7,873					
Ability Network Inc	Data Processing		2,196					
See Supplemental Schedule			11,508				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 116,121				TOTAL	\$ 13,240

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winfield Healthcare Center

0052100

Report Period Beginning:

01/01/15

Ending:

12/31/15

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. ICLTC: \$1,973
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,427 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. \$ 339,988
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.