FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0049502

Facility Name: WINDSOR ESTATES NSG & REHAB

Address: 18300 SOUTH LAVERGNE (Number) TINLEY PARK (City) 60477 (Zip Code)

County: COOK

Telephone Number: (708) 798-2272 **Fax #** (708) 798-2298

HFS ID Number:

Date of Initial License for Current Owners: 03/17/08

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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
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 01/01/2015 to 12/31/2015 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) ELI ATKIN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,680	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	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	5,788	2,222	5,158	13,168	8
9	SNF/PED					9
10	ICF	17,170	2,944		20,114	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,958	5,166	5,158	33,282	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.15%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 12/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 79 and days of care provided 5,082

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

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	277,113	18,185	20,294	315,592		315,592		315,592			1
2	Food Purchase		209,246		209,246		209,246	(1,095)	208,151			2
3	Housekeeping	125,485	35,974		161,459		161,459		161,459			3
4	Laundry	83,058	17,449		100,507		100,507		100,507			4
5	Heat and Other Utilities			132,820	132,820		132,820		132,820			5
6	Maintenance	28,127	18,567	34,026	80,720		80,720	36,080	116,800			6
7	Other (specify):*			26,403	26,403		26,403		26,403			7
8	**TOTAL General Services**	513,783	299,421	213,543	1,026,747		1,026,747	34,985	1,061,732			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	2,004,503	121,526	6,680	2,132,709		2,132,709		2,132,709			10
10a	Therapy		16,880	30,966	47,846		47,846		47,846			10a
11	Activities	128,388	6,730		135,118		135,118		135,118			11
12	Social Services	56,716			56,716		56,716		56,716			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,189,607	145,136	47,646	2,382,389		2,382,389		2,382,389			16
	C. General Administration											
17	Administrative	127,963		260,948	388,911		388,911	(179,772)	209,139			17
18	Directors Fees											18
19	Professional Services			178,071	178,071		178,071	1,337	179,408			19
20	Dues, Fees, Subscriptions & Promotions			117,022	117,022		117,022	(94,946)	22,076			20
21	Clerical & General Office Expenses	57,038	42,286	298,498	397,822		397,822	(132,216)	265,606			21
22	Employee Benefits & Payroll Taxes			596,632	596,632		596,632		596,632			22
23	Inservice Training & Education							504	504			23
24	Travel and Seminar			11,200	11,200		11,200	(6,550)	4,650			24
25	Other Admin. Staff Transportation			64,101	64,101		64,101	(59,351)	4,750			25
26	Insurance-Prop.Liab.Malpractice			224,894	224,894		224,894		224,894			26
27	Other (specify):*			91,111	91,111		91,111	(24,806)	66,305			27
28	**TOTAL General Administration**	185,001	42,286	1,842,477	2,069,764		2,069,764	(495,800)	1,573,964			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,888,391	486,843	2,103,666	5,478,900		5,478,900	(460,815)	5,018,085			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#: WINDSOR ESTATES NSG & REHAB **#0049502** **Report Period Beginning: 01/01/2015** **Ending: 12/31/2015**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,287	
	REPAIRS & MAINTENANCE		1,007	
				20,294
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		34,419	
	ELECTRICITY		75,535	
	WATER		19,921	
	CABLE TV - LOBBY		2,945	
				132,820
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,028	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		977	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,321	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,624	
	FIRE SERVICE		7,076	
				34,026
7	**OTHER**			
	SCAVENGER		25,618	
	SECURITY SERVICE		785	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	671	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		2,200	
	NURSING		3,809	6,680
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	30,966	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				30,966
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	

				26,403
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	10,000	10,000

				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB **#0049502** **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	260,948	260,948
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	55,882	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	122,189	
				178,071
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24,517	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	64,159	
	DUES & SUBSCRIPTIONS	XIX F	13,152	
	LICENSES & PERMITS	XIX F	5,276	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,891	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,628	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,399	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				117,022
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,231	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		254,728	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,334	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		33,205	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	220,454	
	UNEMPLOYMENT COMPENSATION	XIX D	96,013	
	WORKERS COMPENSATION INSURANC	XIX D	85,713	
	HOSPITALIZATION INSURANCE	XIX D	169,027	
	EMPLOYEE BENEFITS - OTHER	XIX D	16,834	
	EMPLOYEE PHYSICAL EXAMS	XIX D	267	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,324	
	CHICAGO HEAD TAX	XIX D	0	
				596,632
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	11,200	
	TRAVEL	XIX G	0	
				11,200
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		64,101	
				64,101
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		224,894	
				224,894
27	**OTHER**			
	BAD DEBTS	VI 24	91,111	
				91,111

GRAND TOTAL COLUMN 3 OTHER **2,103,666**

MESSENGER SERVICE	0	
		298,498

WINDSOR ESTATES NSG & REHAB
SCHEDULES
12/31/2015

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	209,246
LESS SALES TAX	(1,095)
NET FOOD	208,151
TOTAL PATIENT CENSUS	33,282
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	99,846
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	99,846
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	99,846
NET FOOD	208,151
DIVIDE TOTAL MEALS/YEAR	99,846
COST PER MEAL	2.08
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

WINDSOR ESTATES NSG & REHAB
SCHEDULES
12/31/2015

LEGAL FEES

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
	LISTON & TSANTILIS	25,052.51	
	LISTON & TSANTILIS	769.99	
	LM COMMERCIAL REAL ESTATE	5,000.00	
	O'HAGAN LLC	3,701.58	
7/10/2015	O'HAGAN LLC	2,308.50	WILLIE MOORE V. MCALLISTER NURSING
1/31/2015	LEWIS BRISBOIS BISGAARD & SMITH	2,880.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
	LEWIS BRISBOIS BISGAARD & SMITH	464.00	
	LEWIS BRISBOIS BISGAARD & SMITH	897.55	
	LEWIS BRISBOIS BISGAARD & SMITH	1,216.00	
3/30/2015	LEWIS BRISBOIS BISGAARD & SMITH	496.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
5/27/20154	LEWIS BRISBOIS BISGAARD & SMITH	2,208.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
1/6/2015	KLEIN DUB & HOLLEB	5,021.72	GENERAL
2/3/2015	KLEIN DUB & HOLLEB	8,295.08	GENERAL
4/6/2015	KLEIN DUB & HOLLEB	15,521.80	ELECTION & UNION
	KLEIN DUB & HOLLEB	2,449.18	
3/5/2015	KLEIN DUB & HOLLEB	2,609.10	GENERAL
3/2/2015	MARKOFF LEINBERGER	510.00	ANALYSIS AIA DOCUMENTS, DRAFTING MEMO
1/6/2014	MARKOFF LEINBERGER	150.00	GENERAL
1/6/2014	MARKOFF LEINBERGER	2,070.00	GENERAL
1/6/2014	MARKOFF LEINBERGER	701.32	GENERAL
		82,322.33	

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB #0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			8,088	8,088		8,088	208,823	216,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,455	83,455		83,455	223,294	306,749			32
33	Real Estate Taxes			615,657	615,657		615,657		615,657			33
34	Rent-Facility & Grounds			474,000	474,000		474,000	(474,000)				34
35	Rent-Equipment & Vehicles			21,528	21,528		21,528		21,528			35
36	Other (specify):* **amort-comp software**			3,837	3,837		3,837		3,837			36
37	**TOTAL Ownership**			1,206,565	1,206,565		1,206,565	(41,883)	1,164,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,097	622,700	754,797		754,797	(769)	754,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,725	237,725		237,725		237,725			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		132,097	860,425	992,522		992,522	(769)	991,753			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,888,391	618,940	4,170,656	7,677,987		7,677,987	(503,467)	7,174,520			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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	97,597	30		9
10	Interest and Other Investment Income	(63)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,095)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,334)	21		18
19	Entertainment		20		19
20	Contributions	(67,787)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,111)	27		24
25	Fund Raising, Advertising and Promotional	(24,517)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,891)	20		28
29	Other-Attach Schedule	(65,901)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,102)		$	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)	(344,365)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (344,365)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (503,467)		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

STATE OF ILLINOIS

WINDSOR ESTATES NSG & REHAB

ID# 0049502

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE TRANSPORTATION	$ (59,351)	25	1
2	EDUCATION & SEMINARS	(6,550)	24	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				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**	(65,901)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	36,080	0	0	0	0	0	0	0	0	36,080	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,095)	0	36,080	0	0	0	0	0	0	0	0	34,985	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(179,772)	0	0	0	0	0	0	0	0	(179,772)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,337	0	0	0	0	0	0	0	0	1,337	19
20	Fees, Subscriptions & Promotions	(95,195)	0	249	0	0	0	0	0	0	0	0	(94,946)	20
21	Clerical & General Office Expenses	(3,334)	0	(128,882)	0	0	0	0	0	0	0	0	(132,216)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	504	0	0	0	0	0	0	0	0	504	23
24	Travel and Seminar	(6,550)	0	0	0	0	0	0	0	0	0	0	(6,550)	24
25	Other Admin. Staff Transportation	(59,351)	0	0	0	0	0	0	0	0	0	0	(59,351)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(91,111)	0	66,305	0	0	0	0	0	0	0	0	(24,806)	27
28	**TOTAL General Administration**	(255,541)	0	(240,259)	0	0	0	0	0	0	0	0	(495,800)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(256,636)	0	(204,179)	0	0	0	0	0	0	0	0	(460,815)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	97,597	111,226	0	0	0	0	0	0	0	0	0	208,823	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(63)	223,357	0	0	0	0	0	0	0	0	0	223,294	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(474,000)	0	0	0	0	0	0	0	0	0	(474,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	97,534	(139,417)	0	0	0	0	0	0	0	0	0	(41,883)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(769)	0	0	0	0	0	0	0	0	(769)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(769)	0	0	0	0	0	0	0	0	(769)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,102)	(139,417)	(204,948)	0	0	0	0	0	0	0	0	(503,467)	45

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
YAEL ATKIN	46.5	OAKRIDGE HEALTHCARE CENTER,LLC	HILLSIDE, ILL	MCALLISTER		
DONNA ATKIN	46.5			PROPERTY,LLC	TINLEY PARK ILL	REAL ESTATE
HELEN LACEK	7.0					
				OAKRIDGE		
				PROPERTY, LLC	HILLSIDE	REAL ESTATE

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	34	RENT	$ 474,000	MCALLISTER PROPERTY , LLC		$	$ (474,000)	1
2	V	30	DEPRECIATION				111,226	111,226	2
3	V	32	INTEREST				217,492	217,492	3
4	V	32	AMORT OF LOAN COSTS				5,865	5,865	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			$ 474,000			$ 334,583	$ * (139,417)	14

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	39	THERAPY EXPENSE	$ 613,358	INNOVATIVE MANAGEMENT		$	$ (613,358)	15
16	V	21	OUTSIDE CLERICAL	254,728				(254,728)	16
17	V	17	MANAGEMENT FEES	260,948				(260,948)	17
18	V	6	MAINT SUPERVISOR				36,080	36,080	18
19	V	17	ADMINISTRATION- ELI ATKIN				45,152	45,152	19
20	V	17	ADMINISTRATION- JOEL ATKIN				36,024	36,024	20
21	V	21	CLERICAL SALARIES				120,738	120,738	21
22	V	39	REHAB DIRECTOR				53,235	53,235	22
23	V	39	REHAB ASSISTANTS				556,743	556,743	23
24	V	39	OCCUPATIONAL THERAPY				2,611	2,611	24
25	V	27	EMPLOYEE BENEFITS				66,305	66,305	25
26	V	19	DATA PROCESSING				1,337	1,337	26
27	V	20	DUES & SUBSCRIPTIONS				116	116	27
28	V	20	LICENSES & PERMITS				133	133	28
29	V	21	OFFICE EXPENSE				5,108	5,108	29
30	V	23	SEMINARS				504	504	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			$ 1,129,034			$ 924,086	$ * (204,948)	39

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	TZVI ATKIN	administration	ADMINISTRATION		oakridge healthcare	see attached	15.00	SALARY	$ 14,465	17-7	1
2					15,552			P/R TAXES	1,087	27-7	2
3	JOEL ATKIN	OTHER ADMIN	ADMININSTATION AND		oakridge healthcare	see attached	26.67	SALARY	36,024	17-7	3
4			FINANCIAL SERVICES		37,975			P/R TAXES	1,951	27-7	4
5	ELISHA ATKIN	MEMBER	administration		oakridge healthcare	see attached	16.67	SALARY	45,152	17-7	5
6					47,291			P/R TAXES	2,139	27-7	6
7	YOSEF TZADOK	CLERICAL	administration		oakridge healthcare	see attached	15.00	SALARY	14,465	17-7	7
8			ASSIST IN FIN ANALYSIS		15,572			P/R TAXES	1,107	27-7	8
9	COREY FUCHS	CLERICAL			oakridge healthcare	see attached	37.50	SALARY	9,041	17-7	9
10					9,733			P/R TAXES	692	27-7	10
11	HELEN LACEK	ADMINISTRATOR	ADMINISTRATIC	7.00	oakridge healthcare	40		SALARY	127,963	17-1	11
12								P/R TAXES	9,950	22-3	12
13								TOTAL	$ 264,036		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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: INNOVATIVE MANAGEMENT ASSOCIATES,
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE ILL 60053
Phone Number: (708) 798-2272
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT SUPERVISOR	DIRECT	1	1	$ 36,080	$ 36,080	1	$ 36,080	1
2	17	ADMINISTRATION- ELI ATKI	DIRECT	1	1	45,152	45,152	1	45,152	2
3	17	ADMINISTRATION- JOEL ATK	DIRECT	1	1	36,024	36,024	1	36,024	3
4	21	CLERICAL SALARIES	DIRECT	1	1	120,738	120,738	1	120,738	4
5	39	REHAB DIRECTOR	DIRECT	1	1	53,235	53,235	1	53,235	5
6	39	REHAB ASSISTANTS	DIRECT	1	1	556,743	556,743	1	556,743	6
7	39	OCCUPATIONAL THERAPY	DIRECT	1	1	2,611	2,611	1	2,611	7
8	27	EMPLOYEE BENEFITS	DIRECT	1	1	66,305		1	66,305	8
9	19	DATA PROCESSING	AVAILABLE BEDS	233,246	6	7,695		40,515	1,337	9
10	20	DUES & SUBSCRIPTIONS	AVAILABLE BEDS	233,246	6	667		40,515	116	10
11	20	LICENSES & PERMITS	AVAILABLE BEDS	233,246	6	763		40,515	133	11
12	21	OFFICE EXPENSE	AVAILABLE BEDS	233,246	6	29,405		40,515	5,108	12
13	23	SEMINARS	AVAILABLE BEDS	233,246	6	2,899		40,515	504	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					$ 958,317	$ 850,583		$ 924,086	25

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	MC ALLISTER PROPERTY, LLC						$	$			$	1
2	FIRST MERIT BANK			MORTGAGE			4,600,000	4,241,547	7/31/17		217,492	2
3	LOAN COSTS			AMORTIZE OVER LIFE OF LOAN							5,865	3
4												4
5											14,060	5
	Working Capital											
6	FIRST MERIT BANK			WORKING CAPITAL	REVOLV			731,911			45,172	6
7	FIRST INSURANCE FUND			INSURANCE POLICIES FIN							3,514	7
8	CADILLAC			AUTO				30,777			1,163	8
9	TOTAL Facility Related						$ 4,600,000	$ 5,004,235			$ 287,266	9
	B. Non-Facility Related*											
10	COOK COUNTY										13,468	10
11	BED TAX										6,078	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 19,546	14
15	TOTALS (line 9+line14)						$ 4,600,000	$ 5,004,235			$ 306,812	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

*** 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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 304,398	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.)		$ 585,403	2
3. Under or (over) accrual (line 2 minus line 1).		$ 281,005	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 334,652	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.		$ 615,657	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	247,404	8
	2011	336,095	9
	2012	301,223	10
	2013	313,648	11
	2014	534,652	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 81.296% OF THE $534,652.43 2014 RE TAX BILL
MINUS $100,000 EXPECTED BACK FROM 2014 RE TAX BILL
THE PAYMENT ON LINE 2 APPLIES TO THE $534,652.43 2014 TAX BILL PLUS $50,750 ON THE 2013 RE TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDSOR ESTATES NSG & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-043-0000	NURSING HOME	$ 443,489.89	$ 443,489.89
2.	28-33-403-007-0000	NURSING HOME	$ 86,163.99	$ 86,163.99
3.	28-33-403-008-0000	NURSING HOME	$ 4,998.56	$ 4,998.56
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 534,652.44	$ 534,652.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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. [ ] (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).

N/A

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			2008	$ 726,776	1
2					2
3	TOTALS			$ 726,776	3

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	111		2008		$ 2,907,102	$ 105,713	27.5	$ 105,713	$	$ 717,967	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS			2008	4,517	164	27.5	164		1,292	9
10	COVE BASE FLOORING (LANDLORD)			2009	2,520	92	27.5	92		602	10
11	DOORS (LANDLORD)			2009	5,131	186	27.5	186		1,217	11
12	HANDRAILS (LANDLORD)			2009	16,217	590	27.5	590		3,859	12
13	2 NURSE STATIONS (LANDLORD)			2009	3,600	131	27.5	131		857	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)			2009	2,500	91	27.5	91		595	14
15	PYROCHEM SYSTEM (LANDLORD)			2009	3,156	115	27.5	115		752	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)			2009	5,200	189	27.5	189		1,236	16
17	SPRINKLERS (LANDLORD)			2009	38,000	1,382	27.5	1,382		9,041	17
18	SIGNS (LANDLORD)			2009	4,781	174	27.5	174		1,138	18
19	ROOF (LANDLORD)			2009	11,000	399	27.5	399		2,611	19
20	CARPETING (LANDLORD)			2009	4,087		5	817	817	4,086	20
21	PAINTING (LANDLORD)			2009	53,725		5	10,745	10,745	53,726	21
22	CURTAINS (LANDLORD)			2009	19,732		5	3,946	3,946	19,730	22
23	BLINDS (LANDLORD)			2009	4,560		5	912	912	4,560	23
24	DRAPES (LANDLORD)			2010	6,677	191	5	1,335	1,144	5,741	24
25	DRAPES (LANDLORD)			2010	3,662		5	732	732	3,294	25
26	OUTDOOR LIGHTING (LANDLORD)			2010	7,380	492	15	492		2,706	26
27	DRAPES (LANDLORD)			2010	2,817	102	27.5	102		540	27
28	DRAIN LINE (LANDLORD)			2011	3,500	127	27.5	127		513	28
29	HOT WATER HEATER			2012	5,488	200	27.5	200		642	29
30	DRY PIPE VALVE FOR FIRE PROTECTION SYSTEM			2012	3,740	136	27.5	136		436	30
31	REPLACE 2 ROOF TOP HEATING AND A/C UNITS			2013	10,985	400	27.5	400		950	31
32	ALARM SMOKE DETECTORS			2013	3,995	145	27.5	145		344	32
33	NURSE CALL SYSTEM			2013	4,953	180	27.5	180		428	33
34	LIGHT FIXTURES			2013	2,678	97	27.5	97		231	34
35	VALVE FOR FIRE PROTECTION			2013	2,575	94	27.5	94		223	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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,144,278	$ 111,390		$ 129,686	$ 18,296	$ 839,317	70

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 159,518	$ 3,569	$ 15,952	$ 12,383	10 YRS	$ 97,579	71
72	Current Year Purchases	2,175	1,305	109	(1,196)	10YRS	109	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	650,000		65,000	65,000		487,500	74
75	TOTALS	$ 811,693	$ 4,874	$ 81,061	$ 76,187		$ 585,188	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	FACILITY	1996 CHEVY K1500	2009	$ 8,500	$	$ 850	$ 850	10	$ 5,950	76
77	FACILITY	2013 SRX CADILLAC	2013	53,144	3,050	5,314	2,264	10	10,628	77
78										78
79										79
80	TOTALS			$ 61,644	$ 3,050	$ 6,164	$ 3,114		$ 16,578	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)	$ 4,744,391	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,314	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 216,911	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 97,597	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,441,083	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:				$ 474,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 474,000 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 21,528 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			613,358			613,358	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				124,563		124,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	radiology, lab. / Other (specify): medical supplies					9,342	7,534		9,342 / 7,534	13
14	TOTAL			$		$ 622,700	$ 132,097		$ 754,797	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 2,559	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	1,860,038		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	270,705		6
7	Other Prepaid Expenses	5,455		7
8	Accounts Receivable (owners or related parties)	908,466		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,047,223	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,517		15
16	Equipment, at Historical Cost	238,867		16
17	Accumulated Depreciation (book methods)	(192,460)		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): due from mcallister properties	288,131		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 339,055	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,386,278	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,163,627	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	740,179		29
30	Accrued Salaries Payable	136,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,371		31
32	Accrued Real Estate Taxes(Sch.IX-B)	334,652		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,391,774	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,508		39
40	Mortgage Payable			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)**	$ 22,508	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,414,282	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 971,996	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,386,278	$	48

*(See instructions.)

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 856,883	1	
2	Restatements (describe):		2	
3		(2,230)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 854,653	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	117,343	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) OUT OF PERIOD EXPENSES		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 117,343	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)**	$ 971,996	24	*

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 7,547,920	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,547,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,234	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,234	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 63	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)**	$ 7,704,217	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,026,747	31
32	Health Care	2,382,389	32
33	General Administration	2,069,764	33
	B. Capital Expense		
34	Ownership	1,206,565	34
	C. Ancillary Expense		
35	Special Cost Centers	754,797	35
36	Provider Participation Fee	237,725	36
	D. Other Expenses (specify):		
37		(95,113)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,582,874	40
41	**Income before Income Taxes (line 30 minus line 40)****	121,343	41
42	**Income Taxes**	(4,000)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 117,343	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,866,740	44
45	Private Pay - Net Inpatient Revenue	875,904	45
46	Medicare - Net Inpatient Revenue	2,774,253	46
47	Other-(specify)	31,023	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,547,920	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,383	1,469	$ 62,320	$ 42.42	1
2	Assistant Director of Nursing	2,004	2,126	78,339	36.85	2
3	Registered Nurses	10,575	11,028	309,098	28.03	3
4	Licensed Practical Nurses	22,473	23,744	592,205	24.94	4
5	CNAs & Orderlies	79,770	83,537	870,666	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,821	2,086	37,179	17.82	9
10	Activity Assistants	8,451	9,110	91,209	10.01	10
11	Social Service Workers	1,984	2,120	56,716	26.75	11
12	Dietician	1,862	2,086	37,125	17.80	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,848	17,901	181,198	10.12	15
16	Dishwashers	4,270	4,831	58,790	12.17	16
17	Maintenance Workers	2,405	2,649	28,127	10.62	17
18	Housekeepers	12,820	13,341	125,485	9.41	18
19	Laundry	8,842	9,242	83,058	8.99	19
20	Administrator	1,989	2,086	127,963	61.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,470	5,823	57,038	9.80	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	854	918	21,756	23.70	31
32	Other Health C: CARE PLAN	2,753	2,958	70,119	23.70	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,574	197,055	$ 2,888,391 *	$ 14.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 19,287	1-3	35
36	Medical Director	O	10,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	671	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		30,966	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 60,924		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HELEN LACEK	ADMINISTRATOR	7	$ 127,963
	ASST ADMIN		
	OTHER ADMIN		
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,963

B. Administrative - Other

Description	Amount
INNOVATIVE MANAGEMENT FEES	$ 260,948
TOTAL (agree to Schedule V, line 17, col. 3)	$ 260,948
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		178,071
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 178,071

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,713
Unemployment Compensation Insurance	96,013
FICA Taxes	220,454
Employee Health Insurance	169,027
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	16,834
EMPLOYEE PHYSICAL EXAMS	267
PENSION/PROFIT SHARING PLANS	8,324
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 596,632

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	0
Health Care Worker Background Check	3,399
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	67,787
MARKETING/ADV/PROMO	27,408
LICENSES/DUES/SUBSCRIPTIONS	18,428
MGMT CO ALLOC	249
TRUST/FRANCHISE/CONTRIB/ETC	(67,787)
Less: Public Relations Expense	(0)
Non-allowable advertising	(24,517)
Yellow page advertising	(2,891)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,076

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	11,200
SEMINAR EXPENSE	(6,550)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,650

**See instructions.

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 $7,366**

(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? _____ If YES, what is the capacity? **NO**

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(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. _____

(9) Are you presently operating under a sublease agreement? _____ YES _____ 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **237,725**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(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. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
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: _____

(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.