FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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) CNTRY CLUB HILLS (City) 60478 (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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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)	200	45,370	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	0	7,360	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	200	52,730	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	2,554	2,148	8,357	13,059	8
9	SNF/PED					9
10	ICF	21,492	2,427		23,919	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,046	4,575	8,357	36,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.13%

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 12/1/08

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 8,302

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	339,480	52,276	26,157	417,913		417,913		417,913			1
2	Food Purchase		230,209		230,209		230,209	(1,677)	228,532			2
3	Housekeeping	257,897	43,534		301,431		301,431		301,431			3
4	Laundry	98,575	50,638		149,213		149,213		149,213			4
5	Heat and Other Utilities			214,742	214,742		214,742		214,742			5
6	Maintenance	33,858	42,656	100,313	176,827		176,827	25,148	201,975			6
7	Other (specify):* SECURITY	25,403		32,223	57,626		57,626		57,626			7
8	TOTAL General Services	755,213	419,313	373,435	1,547,961		1,547,961	23,471	1,571,432			8
	B. Health Care and Programs											
9	Medical Director			32,000	32,000		32,000		32,000			9
10	Nursing and Medical Records	2,739,808	168,458	8,771	2,917,037		2,917,037		2,917,037			10
10a	Therapy	335,911	14,796	39,842	390,549		390,549		390,549			10a
11	Activities	188,945	17,014		205,959		205,959		205,959			11
12	Social Services	58,317			58,317		58,317		58,317			12
13	CNA Training											13
14	Program Transportation			349	349		349		349			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,322,981	200,268	80,962	3,604,211		3,604,211		3,604,211			16
	C. General Administration											
17	Administrative	177,705		35,531	213,236		213,236	27,983	241,219			17
18	Directors Fees											18
19	Professional Services			204,122	204,122		204,122	(78,640)	125,482			19
20	Dues, Fees, Subscriptions & Promotions			114,190	114,190		114,190	(91,639)	22,551			20
21	Clerical & General Office Expenses	132,603	94,356	337,214	564,173		564,173	(227,050)	337,123			21
22	Employee Benefits & Payroll Taxes			820,209	820,209		820,209		820,209			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,859	4,859		4,859		4,859			24
25	Other Admin. Staff Transportation			70,618	70,618		70,618	(70,618)				25
26	Insurance-Prop.Liab.Malpractice			235,262	235,262		235,262		235,262			26
27	Other (specify):*			171,455	171,455		171,455	(106,962)	64,493			27
28	TOTAL General Administration	310,308	94,356	1,993,460	2,398,124		2,398,124	(546,926)	1,851,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,388,502	713,937	2,447,857	7,550,296		7,550,296	(523,455)	7,026,841			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: 01/01/2016** **Ending: 12/31/2016**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	22,076	
	REPAIRS & MAINTENANCE		3,531	
	OUTSIDE SERVICES		550	26,157
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,253	
	ELECTRICITY		164,901	
	WATER		20,825	
	CABLE TV - LOBBY		3,763	
				214,742
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,885	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		2,049	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,768	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		64,684	
	EXTERMINATING SERVICE		5,960	
	FIRE SERVICE		7,967	
				100,313
7	**OTHER**			
	SCAVENGER		32,223	
	SECURITY SERVICE		0	
				32,223
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	32,000	32,000

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	406	
	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		2,025	
	NURSING		6,340	8,771
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	39,842	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				39,842
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	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB **#0049502** **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		349	
				349
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	35,531	35,531
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	42,080	
	ADMINISTRATIVE CONSULTANTS	XIX C	5,000	
	PROFESSIONAL FEES	XIX C	157,042	
				204,122
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	91,439	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	15,573	
	LICENSES & PERMITS	XIX F	748	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	200	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	6,230	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				114,190
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		17,043	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		257,571	
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,028	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		55,572	
	MESSENGER SERVICE		0	
				337,214

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	333,519	
	UNEMPLOYMENT COMPENSATION	XIX D	168,274	
	WORKERS COMPENSATION INSURANCI	XIX D	62,800	
	HOSPITALIZATION INSURANCE	XIX D	236,527	
	EMPLOYEE BENEFITS - OTHER	XIX D	19,089	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				820,209
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	4,859	
	TRAVEL	XIX G	0	
				4,859
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		70,618	
				70,618
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		235,262	
				235,262
27	**OTHER**			
	BAD DEBTS	VI 24	171,455	
				171,455

GRAND TOTAL COLUMN 3 OTHER **2,447,857**

WINDSOR ESTATES NSG & REHAB
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	230,209
LESS SALES TAX	(1,677)
NET FOOD	228,532
TOTAL PATIENT CENSUS	36,978
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	110,934
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	45,370
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	110,934
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	110,934
NET FOOD	228,532
DIVIDE TOTAL MEALS/YEAR	110,934
COST PER MEAL	2.06
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB #0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			212,751	212,751		212,751	406,586	619,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,257	93,257		93,257	1,600,873	1,694,130			32
33	Real Estate Taxes			531,930	531,930		531,930		531,930			33
34	Rent-Facility & Grounds			1,233,000	1,233,000		1,233,000	(1,233,000)				34
35	Rent-Equipment & Vehicles			49,781	49,781		49,781		49,781			35
36	Other (specify):* **amort-comp software**			4,648	4,648		4,648		4,648			36
37	**TOTAL Ownership**			2,125,367	2,125,367		2,125,367	774,459	2,899,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,231	570,676	846,907		846,907	(59,903)	787,004			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,775	246,775		246,775		246,775			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		276,231	817,451	1,093,682		1,093,682	(59,903)	1,033,779			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,388,502	990,168	5,390,675	10,769,345		10,769,345	191,101	10,960,446			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: 01/01/2016 Ending: 12/31/2016

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	(2,685,508)	30		9
10	Interest and Other Investment Income	(148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,677)	2		13
14	Non-Care Related Interest	(44,623)	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	(7,028)	21		18
19	Entertainment		20		19
20	Contributions	(200)	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	(171,455)	27		24
25	Fund Raising, Advertising and Promotional	(91,439)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(239,406)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,241,484)		$	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)	3,432,585		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,432,585		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 191,101		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WINDSOR ESTATES NSG & REHAB

ID# 0049502

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (17,043)	21	1
2	NON ALLOWABLE TRANSPORTATION	(70,618)	25	2
3	MARKETING SALARIES	(73,105)	21	3
4	NON ALLOWABLE LEGAL FEES	(78,640)	19	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**	(239,406)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,677)	0	0	0	0	0	0	0	0	0	0	(1,677)	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	25,148	0	0	0	0	0	0	0	0	25,148	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,677)	0	25,148	0	0	0	0	0	0	0	0	23,471	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	27,983	0	0	0	0	0	0	0	0	27,983	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(78,640)	0	0	0	0	0	0	0	0	0	0	(78,640)	19
20	Fees, Subscriptions & Promotions	(91,639)	0	0	0	0	0	0	0	0	0	0	(91,639)	20
21	Clerical & General Office Expenses	(97,176)	0	(129,874)	0	0	0	0	0	0	0	0	(227,050)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(70,618)	0	0	0	0	0	0	0	0	0	0	(70,618)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(171,455)	0	64,493	0	0	0	0	0	0	0	0	(106,962)	27
28	TOTAL General Administration	(509,528)	0	(37,398)	0	0	0	0	0	0	0	0	(546,926)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(511,205)	0	(12,250)	0	0	0	0	0	0	0	0	(523,455)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,685,508)	3,092,094	0	0	0	0	0	0	0	0	0	406,586	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44,771)	1,645,644	0	0	0	0	0	0	0	0	0	1,600,873	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,233,000)	0	0	0	0	0	0	0	0	0	(1,233,000)	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**	(2,730,279)	3,504,738	0	0	0	0	0	0	0	0	0	774,459	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	(59,903)	0	0	0	0	0	0	0	0	(59,903)	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	(59,903)	0	0	0	0	0	0	0	0	(59,903)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,241,484)	3,504,738	(72,153)	0	0	0	0	0	0	0	0	191,101	45

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Abington of Glenview Nursing & Rehab	GLENVIEW, IL			
				OAKRIDGE		
				PROPERTY, LLC	HILLSIDE	REAL ESTATE
				INNOVATIVE MGT	MORTON GROVE	MANAGEMENT

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	$ 1,233,000	MCALLISTER PROPERTY , LLC		$	$ (1,233,000)	1
2	V	30	DEPRECIATION				3,092,094	3,092,094	2
3	V	32	INTEREST				1,574,981	1,574,981	3
4	V	32	AMORT OF LOAN COSTS				70,663	70,663	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,233,000			$ 4,737,738	$ * 3,504,738	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: 01/01/2016 Ending: 12/31/2016

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	$ 555,252	INNOVATIVE MANAGEMENT		$	$ (555,252)	15
16	V	21	OUTSIDE CLERICAL	257,571				(257,571)	16
17	V	17	MANAGEMENT FEES	35,531				(35,531)	17
18	V	6	MAINTENANCE SALARIES				25,148	25,148	18
19	V	17	Administrator- ELI ATKIN				31,757	31,757	19
20	V	17	Administration- JOEL ATKIN				31,757	31,757	20
21	V	21	CLERICAL SALARIES				127,697	127,697	21
22	V	39	REHAB DIRECTOR				24,335	24,335	22
23	V	39	REHAB ASSISTANTS				471,014	471,014	23
24	V	27	EMPLOYEE BENEFITS				64,493	64,493	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			$ 848,354			$ 776,201	$ * (72,153)	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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	TZVI (STEVE) ATKIN	OTHER ADMIN	Administration		see attached	see attached		SALARY	$ 10,955	21-7	1
2						10	25.00	P/R TAXES	992	27-7	2
3	JOEL ATKIN	OTHER ADMIN	Administration ans		see attached	see attached		SALARY	31,757	17-7	3
4			Financial Servise			8	26.67	P/R TAXES	2,878	27-7	4
5	ELISHA ATKIN	ADMINISTRATOR	Adiministator		see attached	see attached		SALARY	31,757	17-7	5
6						5	16.67	P/R TAXES	2,878	27-7	6
7											7
8											8
9	COREY FUCHS	CLERICAL	Bookkeeping		see attached	see attached		SALARY	9,417	21-7	9
10						15	37.50	P/R TAXES	853	27-7	10
11	HELEN LACEK	ADMINISTRATOR	ADMINISTRATION		0	40	85.10	SALARY	157,819	17-1	11
12								P/R TAXES	9,723	22-3	12
13								TOTAL	$ 259,029		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: 01/01/2016 Ending: 2/31/2016

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 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						$	$		$	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 WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	MAINTENANCE SALARIES	DIRECT	1	1	$ 25,148	$ 25,148	1	$ 25,148	1
2	17	Administrator- ELI ATKIN	DIRECT	1	1	31,757	31,757	1	31,757	2
3	17	Administration- JOEL ATKIN	DIRECT	1	1	31,757	31,757	1	31,757	3
4	21	CLERICAL SALARIES	DIRECT	1	1	127,697	127,697	1	127,697	4
5	39	REHAB DIRECTOR	DIRECT	1	1	24,335	24,335	1	24,335	5
6	39	REHAB ASSISTANTS	DIRECT	1	1	471,014	471,014	1	471,014	6
7	27	EMPLOYEE BENEFITS	DIRECT	1	1	64,493		1	64,493	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					$ 776,201	$ 711,708		$ 776,201	25

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		X	MORTGAGE	$133,422.64	3/31/14	23,947,000	22,944,562	04/01/19	0.0428	1,158,312	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							70,663	3
4	ABILITY INSURANCE		X	2ND MORTGAGE	INT ONLY	3/31/14	5,625,000	5,625,000			414,531	4
5	SUSQUEHANNA FINANCE		X	WASHER & DRYER		867.14	43,948	40,051	01/09/21	0.0625	2,138	5
	Working Capital											
6	FIRST MERIT BANK			WORKING CAPITAL	REVOLV			1,200,000		PRIME +	44,051	6
7	FIRST INSURANCE FUND			INSURANCE POLICIES FIN							3,681	7
8	CADILLAC			AUTO	$750.65	5/14/13	49,551	21,018	05/14/19	0.0290	902	8
9	TOTAL Facility Related				$134,173.29		$ 29,665,499	$ 29,830,631			$ 1,694,278	9
	B. Non-Facility Related*											
10	COOK COUNTY										26,218	10
11	BED TAX										4,564	11
12	JACK ATKIN, UNITED RX										13,841	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 44,623	14
15	TOTALS (line 9+line14)						$ 29,665,499	$ 29,830,631			$ 1,738,901	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** 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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	334,652	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.)	$	294,059	2
3. Under or (over) accrual (line 2 minus line 1).	$	188,639	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	572,523	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** $ 200 **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.	$	531,930	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	336,095	8
	2012	301,223	9
	2013	313,648	10
	2014	534,652	11
	2015	523,291	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON $229,232.11 OWED ON 2ND INSTALLMENT OF THE 2015 BILLS + (100% OF THE 523,291 2015 RE TAX BILLS MINUS $180,000 EXPECTED REDUCTION)

THE PAYMENT ON LINE 2 APPLIES TO THE 1ST INSTALLMENT OF THE 2015 TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-043-0000	NURSING HOME	$ 431,056.23	$ 431,056.23
2.	28-33-403-007-0000	NURSING HOME	$ 87,146.83	$ 87,146.83
3.	28-33-403-008-0000	NURSING HOME	$ 5,087.89	$ 5,087.89
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 523,290.95	$ 523,290.95

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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			2016	338,000	2
3	TOTALS			$ 1,064,776	3

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	$ 929,393	4
5	200		2016	2016	20,168,339	194,221	39	194,221		194,221	5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS			2008	4,517	164	27.5	164		1,456	9
10	COVE BASE FLOORING (LANDLORD)			2009	2,520	92	27.5	92		694	10
11	DOORS (LANDLORD)			2009	5,131	186	27.5	186		1,403	11
12	HANDRAILS (LANDLORD)			2009	16,217	590	27.5	590		4,449	12
13	2 NURSE STATIONS (LANDLORD)			2009	3,600	131	27.5	131		988	13
14	FIRE SPRINKLER SYSTEM (LANDLORD)			2009	2,500	91	27.5	91		686	14
15	PYROCHEM SYSTEM (LANDLORD)			2009	3,156	115	27.5	115		867	15
16	NURSE CALL LIGHT SYSTEM (LANDLORD)			2009	5,200	189	27.5	189		1,425	16
17	SPRINKLERS (LANDLORD)			2009	38,000	1,382	27.5	1,382		10,423	17
18	SIGNS (LANDLORD)			2009	4,781	174	27.5	174		1,312	18
19	ROOF (LANDLORD)			2009	11,000	399	27.5	399		3,010	19
20	CARPETING (LANDLORD)			2009	4,087		5	1	1	4,087	20
21	PAINTING (LANDLORD)			2009	53,725		5	(1)	(1)	53,725	21
22	CURTAINS (LANDLORD)			2009	19,732		5	2	2	19,732	22
23	BLINDS (LANDLORD)			2009	4,560		5			4,560	23
24	DRAPES (LANDLORD)			2010	6,677		5	936	936	6,677	24
25	DRAPES (LANDLORD)			2010	3,662		5	368	368	3,662	25
26	OUTDOOR LIGHTING (LANDLORD)			2010	7,380	492	15	492		3,198	26
27	DRAPES (LANDLORD)			2010	2,817	102	27.5	102		642	27
28	DRAIN LINE (LANDLORD)			2011	3,500	127	27.5	127		640	28
29	HOT WATER HEATER			2012	5,488	200	27.5	200		842	29
30	DRY PIPE VALVE FOR FIRE PROTECTION SYSTEM			2012	3,740	136	27.5	136		572	30
31	REPLACE 2 ROOF TOP HEATING AND A/C UNITS			2013	10,985	400	27.5	400		1,350	31
32	ALARM SMOKE DETECTORS			2013	3,995	145	27.5	145		489	32
33	NURSE CALL SYSTEM			2013	4,953	180	27.5	180		608	33
34	LIGHT FIXTURES			2013	2,678	97	27.5	97		328	34
35	VALVE FOR FIRE PROTECTION			2013	2,575	94	27.5	94		317	35
36	ASPHALT PAVING			2016	349,559	183,519	15	8,739		8,739	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: 01/01/2016 Ending: 12/31/2016

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	CONCRETE PAVING	2016	$ 161,155	$ 84,606	15	$ 4,029	$ (80,577)	$ 4,029	37
38	LANDSCAPING	2016	458,622	240,777	15	11,466	(229,311)	11,466	38
39	LIGHTING SITE	2016	108,095	56,750	15	2,703	(54,047)	2,703	39
40	MONUMENT SIGN	2016	20,549	10,788	15	514	(10,274)	514	40
41	SITE SIGNAGE	2016	19,109	10,032	15	477	(9,555)	477	41
42	STORM WATER SYSTEM	2016	130,325	68,421	15	3,258	(65,163)	3,258	42
43	LANDSCAPING	2016	24,325	12,569	15	406	(12,163)	406	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)		$ 24,584,356	$ 972,882		$ 338,318	$ (459,784)	$ 1,283,348	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: 01/01/2016 Ending: 12/31/2016

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	$ 161,693	$ 5,866	$ 16,170	$ 10,304		$ 113,858	71
72	Current Year Purchases	341,409	204,846	17,070	(187,776)		17,070	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	4,182,294	2,119,376	241,615	(1,877,761)		729,115	74
75	TOTALS	$ 4,685,396	$ 2,330,088	$ 274,855	$ (2,055,233)		$ 860,043	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	$ 6,800	76
77	FACILITY	2013 SRX CADILLAC	2013	53,144	1,875	5,314	3,439	10	15,942	77
78										78
79										79
80	TOTALS			$ 61,644	$ 1,875	$ 6,164	$ 4,289		$ 22,742	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)	$ 30,396,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,304,845	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 619,337	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,685,508)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,166,133	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: 01/01/2016 Ending: 12/31/2016

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:				$ 1,233,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 1,233,000 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 49,781 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: 01/01/2016 Ending: 12/31/2016

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.

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

	1	2	3	4	5	6	7	8	
	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	39-3	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			555,252			555,252	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				267,559		267,559	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					15,424	8,672		15,424 8,672	13
14	TOTAL			$		$ 570,676	$ 276,231		$ 846,907	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 WINDSOR ESTATES NSG & REHAB **#** 0049502 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ 998	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	3,386,195		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	361,918		6
7	Other Prepaid Expenses	6,720		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): refund due from il dept of revenu	1,270		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,757,101	$	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	580,276		16
17	Accumulated Depreciation (book methods)	(409,859)		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	655,154		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 830,088	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,587,189	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,363,803	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,221,018		29
30	Accrued Salaries Payable	302,749		30
31	Accrued Taxes Payable (excluding real estate taxes)	108,370		31
32	Accrued Real Estate Taxes(Sch.IX-B)	572,523		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)**	$ 4,568,463	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,568,463	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,726	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,587,189	$	48

***(See instructions.)**

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 971,996	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 971,996	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(953,270)	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)**	$ (953,270)	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)**	$ 18,726	24 *

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

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 9,688,178	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,688,178	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,929	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,929	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***	148	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 148	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)**	$ 9,839,255	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,547,961	31
32	Health Care	3,604,211	32
33	General Administration	2,398,124	33
	B. Capital Expense		
34	Ownership	2,125,367	34
	C. Ancillary Expense		
35	Special Cost Centers	846,907	35
36	Provider Participation Fee	246,775	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	23,180	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,792,525	40
41	**Income before Income Taxes (line 30 minus line 40)****	(953,270)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (953,270)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,229,830	44
45	Private Pay - Net Inpatient Revenue	839,524	45
46	Medicare - Net Inpatient Revenue	4,557,363	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	61,461	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,688,178	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: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,199	$ 97,028	$ 44.12	1
2	Assistant Director of Nursing	2,026	2,263	84,570	37.37	2
3	Registered Nurses	9,555	9,956	284,028	28.53	3
4	Licensed Practical Nurses	37,891	39,553	1,029,432	26.03	4
5	CNAs & Orderlies	92,015	95,498	1,085,727	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,127	8,433	335,911	39.83	8
9	Activity Director	1,851	2,105	40,368	19.18	9
10	Activity Assistants	13,234	14,137	148,577	10.51	10
11	Social Service Workers	2,902	3,049	58,317	19.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,623	24,535	280,554	11.43	15
16	Dishwashers	4,325	4,566	58,926	12.91	16
17	Maintenance Workers	2,574	2,669	33,858	12.69	17
18	Housekeepers	24,551	25,274	257,897	10.20	18
19	Laundry	9,601	10,100	98,575	9.76	19
20	Administrator	2,477	2,560	177,705	69.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,235	8,580	132,603	15.45	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	4,168	4,349	58,109	13.36	31
32	Other Health Care(specify)	3,147	3,341	100,914	30.20	32
33	Other(specify) SECURITY	1,584	1,600	25,403	15.88	33
34	TOTAL (lines 1 - 33)	253,886	264,767	$ 4,388,502 *	$ 16.57	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	$ 22,076	1-3	35
36	Medical Director	O	32,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	406	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		39,842	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)		$ 94,324		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: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HELEN LACEK	ADMINISTRATOR	7	$ 157,819
	ASST ADMIN		0
	OTHER ADMIN		0
TAMRA MCDERMAND	ADMINISTRATOR		7,770
PENNY VARNAVAS			12,116
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 177,705

B. Administrative - Other

Description	Amount
MANAGEMENT FEES- INNOVATIVE	$ 35,531
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 35,531

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		204,122
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 204,122

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 62,800
Unemployment Compensation Insurance		168,274
FICA Taxes		333,519
Employee Health Insurance		236,527
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		19,089
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 820,209

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	0
Health Care Worker Background Check	6,230
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	200
MARKETING/ADV/PROMO	91,439
LICENSES/DUES/SUBSCRIPTIONS	16,321
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(200)
Less: Public Relations Expense	(0)
Non-allowable advertising	(91,439)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,551

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	4,859
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,859

* Attach copy of IMRF notifications

**See instructions.

WINDSOR ESTATES NSG & REHAB
SCHEDULE-LEGAL
12/31/2016

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
	COHEN SALK & HUVARD	3,000.00	
	O'HAGAN LLC	459.00	
	O'HAGAN LLC	38,768.50	
	O'HAGAN LLC	5,249.50	
	ROBBINS SOLOMON	10,000.00	
	K & L	17,411.50	
	K & L	375.00	
	LEWIS BRISBOIS BISGAARD & SMITH	128.00	
	LEWIS BRISBOIS BISGAARD & SMITH	464.00	
	LEWIS BRISBOIS BISGAARD & SMITH	320.00	
	LEWIS BRISBOIS BISGAARD & SMITH	656.00	
	LEWIS BRISBOIS BISGAARD & SMITH	256.00	
1/31/2016	LEWIS BRISBOIS BISGAARD & SMITH	735.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
2/18/2016	LEWIS BRISBOIS BISGAARD & SMITH	147.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
3/31/2016	LEWIS BRISBOIS BISGAARD & SMITH	714.00	JAMES,ELGIN V. MCALLISTER NURSING & REHAB
	KLEIN DUB & HOLLEB	356.25	
	KLEIN DUB & HOLLEB	118.75	
	KLEIN DUB & HOLLEB	118.75	
	KLEIN DUB & HOLLEB	118.75	
	KLEIN DUB & HOLLEB	840.25	
		80,236.25	

Facility Name & ID Number WINDSOR ESTATES NSG & REHAB # 0049502 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 $9,990**

(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. $ **246,775**
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