FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0049502

Facility Name: WINDSOR ESTATES NURSING & REHAB

Address: 18300 S. LAVERGNE (Number) COUNTRY 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 01/01/2017 to 12/31/2017 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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	200	Skilled (SNF)	200	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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		5,891	16,782	22,673	8
9	SNF/PED					9
10	ICF	28,869			28,869	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,869	5,891	16,782	51,542	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.61%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

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

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 16,697

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	599,674	62,273	26,352	688,299		688,299		688,299			1
2	Food Purchase		321,413		321,413		321,413		321,413			2
3	Housekeeping	410,330	60,935		471,265		471,265		471,265			3
4	Laundry	118,027	32,048	2,638	152,713		152,713		152,713			4
5	Heat and Other Utilities			244,754	244,754		244,754		244,754			5
6	Maintenance	162,918	28,769	92,891	284,578		284,578		284,578			6
7	Other (specify):*			25,641	25,641		25,641		25,641			7
8	**TOTAL General Services**	1,290,949	505,438	392,276	2,188,663		2,188,663		2,188,663			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	4,670,562	256,948	14,383	4,941,893		4,941,893		4,941,893			10
10a	Therapy	1,453,323	5,288	55,285	1,513,896		1,513,896		1,513,896			10a
11	Activities	227,268	26,831		254,099		254,099		254,099			11
12	Social Services	60,886			60,886		60,886		60,886			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	34,635			34,635		34,635		34,635			15
16	**TOTAL Health Care and Programs**	6,446,674	289,067	111,668	6,847,409		6,847,409		6,847,409			16
	C. General Administration											
17	Administrative	51,124		65,000	116,124		116,124	47,392	163,516			17
18	Directors Fees											18
19	Professional Services			166,027	166,027		166,027	4,200	170,227			19
20	Dues, Fees, Subscriptions & Promotions			65,945	65,945		65,945	(38,473)	27,472			20
21	Clerical & General Office Expenses	246,153	77,113	345,346	668,612		668,612	(321,700)	346,912			21
22	Employee Benefits & Payroll Taxes			1,163,083	1,163,083		1,163,083		1,163,083			22
23	Inservice Training & Education			16,846	16,846		16,846		16,846			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,632	4,632		4,632		4,632			25
26	Insurance-Prop.Liab.Malpractice			327,756	327,756		327,756		327,756			26
27	Other (specify):*			321,337	321,337		321,337	(304,088)	17,249			27
28	**TOTAL General Administration**	297,277	77,113	2,475,972	2,850,362		2,850,362	(612,669)	2,237,693			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,034,900	871,618	2,979,916	11,886,434		11,886,434	(612,669)	11,273,765			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 NURSING & REHAB **#0049502** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	25,265	
	REPAIRS & MAINTENANCE		1,087	
				26,352
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,638	
				2,638
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		29,103	
	ELECTRICITY		136,165	
	WATER		75,082	
	CABLE TV - LOBBY		4,404	
				244,754
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		28,135	
	PAINTING & DECORATING		2,406	
	BUILDING REPAIRS		1,957	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		35,390	
	ELEVATOR MAINTENANCE & REPAIR		8,204	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,123	
	FIRE SERVICE		9,676	
				92,891
7	**OTHER**			
	SCAVENGER		25,227	
	SECURITY SERVICE		414	
				25,641
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	42,000	42,000

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	0	
	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		1,100	
	NURSING		13,283	14,383
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	55,285	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				55,285
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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB **#0049502** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	65,000	65,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	68,806	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	97,221	
				166,027
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	37,973	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,274	
	LICENSES & PERMITS	XIX F	10,336	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	500	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	12,862	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				65,945
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		20,127	
	EQUIPMENT REPAIR & MAINTENANCE		1,394	
	OUTSIDE CLERICAL SERVICES		269,276	
	PENALTIES / OVERDRAFT CHARGES	VI 18	12,971	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,398	
	TELEPHONE		40,180	
	MESSENGER SERVICE		0	
				345,346

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	614,670	
	UNEMPLOYMENT COMPENSATION	XIX D	188,592	
	WORKERS COMPENSATION INSURANC	XIX D	78,754	
	HOSPITALIZATION INSURANCE	XIX D	271,351	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,716	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				1,163,083
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		16,846	
				16,846
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,632	
				4,632
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		327,756	
				327,756
27	**OTHER**			
	BAD DEBTS	VI 24	321,337	
				321,337

GRAND TOTAL COLUMN 3 OTHER **2,979,916**

WINDSOR ESTATES NURSING & REHAB
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	321,413
LESS SALES TAX	0
NET FOOD	321,413
TOTAL PATIENT CENSUS	51,542
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	154,626
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	73,000
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	154,626
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	154,626
NET FOOD	321,413
DIVIDE TOTAL MEALS/YEAR	154,626
COST PER MEAL	2.08
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB #0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			71,589	71,589		71,589	919,951	991,540			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,626	168,626		168,626	2,057,477	2,226,103			32
33	Real Estate Taxes			277,109	277,109		277,109		277,109			33
34	Rent-Facility & Grounds			2,520,000	2,520,000		2,520,000	(2,520,000)				34
35	Rent-Equipment & Vehicles			165,903	165,903		165,903		165,903			35
36	Other (specify):* **Amort-comp software**			2,010	2,010		2,010		2,010			36
37	**TOTAL Ownership**			3,205,237	3,205,237		3,205,237	457,428	3,662,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		513,776	29,778	543,554		543,554		543,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,919	313,919		313,919		313,919			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		513,776	343,697	857,473		857,473		857,473			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,034,900	1,385,394	6,528,850	15,949,144		15,949,144	(155,241)	15,793,903			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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(204,744)	30		9
10	Interest and Other Investment Income	(4,296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(86,061)	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	(12,971)	21		18
19	Entertainment		20		19
20	Contributions		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	(321,337)	27		24
25	Fund Raising, Advertising and Promotional	(37,973)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(500)	20		28
29	Other-Attach Schedule SEE PG 5A	(157,618)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (825,500)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	670,259		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 670,259		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (155,241)		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 NURSING & REHAB

ID# 0049502

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (20,029)	21	1
2	MARKETING SALARIES	(137,589)	21	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**	(157,618)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB **#** 0049502 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	47,392	0	0	0	0	0	0	0	0	47,392	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,200	0	0	0	0	0	0	0	0	0	4,200	19
20	Fees, Subscriptions & Promotions	(38,473)	0	0	0	0	0	0	0	0	0	0	(38,473)	20
21	Clerical & General Office Expenses	(170,589)	0	(151,111)	0	0	0	0	0	0	0	0	(321,700)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(321,337)	0	17,249	0	0	0	0	0	0	0	0	(304,088)	27
28	**TOTAL General Administration**	(530,399)	4,200	(86,470)	0	0	0	0	0	0	0	0	(612,669)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(530,399)	4,200	(86,470)	0	0	0	0	0	0	0	0	(612,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(204,744)	1,124,695	0	0	0	0	0	0	0	0	0	919,951	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(90,357)	2,147,834	0	0	0	0	0	0	0	0	0	2,057,477	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(2,520,000)	0	0	0	0	0	0	0	0	0	(2,520,000)	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	(295,101)	752,529	0	0	0	0	0	0	0	0	0	457,428	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(825,500)	756,729	(86,470)	0	0	0	0	0	0	0	0	(155,241)	45

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	HILLSIDE	
				PROPERTY, LLC		
				ABINGTON OF	GLENVIEW	REAL ESTATE
				GLENVIEW, PROP		
				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	$ 2,520,000	MCALLISTER PROPERTY , LLC		$	$ (2,520,000)	1
2	V	19	PROFESSIONAL FEES				4,200	4,200	2
3	V	30	DEPRECIATION				1,124,695	1,124,695	3
4	V	32	INTEREST				2,044,201	2,044,201	4
5	V	32	AMORT OF LOAN COSTS				103,633	103,633	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			$ 2,520,000			$ 3,276,729	$ * 756,729	14

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	21	Outside Clerical	$ 271,987	INNOVATIVE MANAGEMENT		$	$ (271,987)	15
16	V	17	Management Fees	65,000				(65,000)	16
17	V	17	Administrator- Eli Atkin				39,565	39,565	17
18	V	17	Administration- Joel Atkin				39,565	39,565	18
19	V	17	Admiinistrator- Helen Lacek				33,262	33,262	19
20	V	21	Clerical Salaries- Tzvi Atkin				18,302	18,302	20
21	V	21	Clerical Salaries- Corey Fuchs				14,055	14,055	21
22	V	21	Clerical Salaries- Yosef Tsadok				525	525	22
23	V	21	Clerical Salaries				87,994	87,994	23
24	V	27	Payroll Taxes				17,249	17,249	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			$ 336,987			$ 250,517	$ * (86,470)	39

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 NURSING & REHAI # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 18,302	17-7	1
2						10					2
3	JOEL ATKIN	OTHER ADMIN	Administration ans		see attached	see attached		SALARY	39,565	17-7	3
4			Financial Servise			8					4
5	ELISHA ATKIN	ADMINISTRATOR	Adiministator		see attached	see attached		SALARY	39,565	17-7	5
6						5					6
7	JOHN LACEK	MAINTENANCE	MAINTENANCE					SALARY	30,870	6-1	7
8	JOSEPH TSADOK	CLERICAL	Asst in Fin Analysis					SALARY	525	17-7	8
9	COREY FUCHS	CLERICAL	Bookkeeping		see attached	see attached		SALARY	14,055	17-7	9
10						15					10
11	HELEN LACEK	ADMINISTRATOR	ADMINISTRATIC	5.00	0	40		SALARY	33,262	17-7	11
12								SALARY	6,449	17-1	12
13								TOTAL	$ 182,593		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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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) 573-1100
Fax Number: (708) 573-1720

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrator- Eli Atkin	Available Beds	369,015	7	$ 200,000	$ 200,000	73,000	$ 39,565	1
2	17	Administration- Joel Atkin	Available Beds	369,015	7	200,000	200,000	73,000	39,565	2
3	17	Admiinistrator- Helen Lacek	Available Beds	369,015	7	168,140	168,140	73,000	33,262	3
4	21	Clerical Salaries- Tzvi Atkin	Available Beds	369,015	7	92,516	92,516	73,000	18,302	4
5	21	Clerical Salaries- Corey Fuchs	Available Beds	369,015	7	71,046	71,046	73,000	14,055	5
6	21	Clerical Salaries- Yosef Tsadok	Available Beds	369,015	7	2,654	2,654	73,000	525	6
7	21	Clerical Salaries	Available Beds	369,015	7	444,808	444,808	73,000	87,994	7
8	27	Payroll Taxes	Available Beds	369,015	7	87,195		73,000	17,249	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					$ 1,266,359	$ 1,179,164		$ 250,517	25

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	22,705,959	04/01/19	0.0428	1,579,003	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		01/15/16	336,808	171,800			103,633	3
4	ABILITY INSURANCE	X		2ND MORTGAGE	INT ONLY	3/31/14	5,625,000	5,625,000			463,094	4
5	SUSQUEHANNA FINANCE		X	WASHER & DRYER							2,104	5
	Working Capital											
6	HUNTINGTON BANK		X	WORKING CAPITAL	REVOLV			1,180,000		PRIME +	75,676	6
7	FIRST INSURANCE FUND		X	INSURANCE POLICIES FIN							6,889	7
8												8
9	TOTAL Facility Related				$133,422.64		$ 29,908,808	$ 29,682,759			$ 2,230,399	9
	B. Non-Facility Related*											
10	COOK COUNTY										72,350	10
11	BED TAX										2,106	11
12	JACK ATKIN, UNITED RX										11,605	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 86,061	14
15	TOTALS (line 9+line14)						$ 29,908,808	$ 29,682,759			$ 2,316,460	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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	572,523	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.)	$	274	2
3. Under or (over) accrual (line 2 minus line 1).	$	(69,870)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	693,683	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.	$	277,109	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	301,223	8
	2013	313,648	9
	2014	534,652	10
	2015	523,291	11
	2016	346,979	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON $346,704.22 OWED ON THE 2016 TAX BILL AND ON ~100% OF THE $346,978.50 2016 REAL ESTATE TAX BILL FOR 2017

THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDSOR ESTATES NURSING & 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-004-0000	NURSING HOME	$ 73,805.42	$ 73,805.42
2.	28-33-403-005-0000	NURSING HOME	$ 118,704.75	$ 118,704.75
3.	28-33-403-044-0000	NURSING HOME	$ 154,468.33	$ 154,468.33
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 346,978.50	$ 346,978.50

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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				$	1
2			2016	371,149	2
3	TOTALS			$ 371,149	3

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	200		2016	2016	$ 20,168,339	$ 517,137	39	$ 517,137	$	$ 711,358	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASPHALT PAVING			2016	349,559	11,652	15	23,304	11,652	32,043	9
10	CONCRETE PAVING			2016	161,155	5,372	15	10,744	5,372	14,773	10
11	LANDSCAPING			2016	458,622	15,287	15	30,575	15,288	42,041	11
12	LIGHTING SITE			2016	108,095	3,603	15	7,206	3,603	9,909	12
13	MONUMENT SIGN			2016	20,549	685	15	1,370	685	1,884	13
14	SITE SIGNAGE			2016	19,109	637	15	1,274	637	1,751	14
15	STORM WATER SYSTEM			2016	130,325	4,344	15	8,688	4,344	11,946	15
16	LANDSCAPING			2016	24,325	811	15	1,622	811	2,028	16
17						164			(164)		17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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)		$ 21,440,078	$ 559,692		$ 601,920	$ 42,228	$ 827,733	70

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 341,409	$ 54,625	$ 34,141	$ (20,484)	10 YRS	$ 51,211	71
72	Current Year Purchases	28,000	16,800	1,400	(15,400)	10 YRS	1,400	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	3,532,294	565,167	353,229	(211,938)	10 YRS	529,844	74
75	TOTALS	$ 3,901,703	$ 636,592	$ 388,770	$ (247,822)		$ 582,455	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	$ 7,650	76
77										77
78										78
79										79
80	TOTALS			$ 8,500	$	$ 850	$ 850		$ 7,650	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)	$ 25,721,430	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,196,284	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 991,540	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (204,744)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,417,838	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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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:				$ 2,520,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 2,520,000 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 165,903 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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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							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				508,468		508,468	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2				29,778	5,308		29,778 5,308	13
14	TOTAL			$		$ 29,778	$ 513,776		$ 543,554	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 NURSING & REHAB **#** 0049502 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 **(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	$ 279,920	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (185,000))	6,319,744		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	485,655		6
7	Other Prepaid Expenses	8,433		7
8	Accounts Receivable (owners or related parties)	196		8
9	Other(specify): exchange	40,978		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,134,926	$	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	555,132		16
17	Accumulated Depreciation (book methods)	(462,273)		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	567,255		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 664,631	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,799,557	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,010,240	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,180,000		29
30	Accrued Salaries Payable	352,907		30
31	Accrued Taxes Payable (excluding real estate taxes)	593,156		31
32	Accrued Real Estate Taxes(Sch.IX-B)	693,683		32
33	Accrued Interest Payable	48,251		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates	3,753,572		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,631,809	$	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)**	$ 8,631,809	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (832,252)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,799,557	$	48

***(See instructions.)**

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,726	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(1,210,675)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,191,949)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	292,192	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 TRANSACTIONS	67,505	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 359,697	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)**	$ (832,252)	24 *

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 15,965,549	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,965,549	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	270,892	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 270,892	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***	4,296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,296	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	599	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 599	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,241,336	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,188,663	31
32	Health Care	6,847,409	32
33	General Administration	2,850,362	33
	B. Capital Expense		
34	Ownership	3,205,237	34
	C. Ancillary Expense		
35	Special Cost Centers	543,554	35
36	Provider Participation Fee	313,919	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,949,144	40
41	**Income before Income Taxes (line 30 minus line 40)****	292,192	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 292,192	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,909,558	44
45	Private Pay - Net Inpatient Revenue	1,440,932	45
46	Medicare - Net Inpatient Revenue	9,568,954	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	46,105	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,965,549	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,045	2,121	$ 103,129	$ 48.62	1
2	Assistant Director of Nursing	3,137	3,242	110,143	33.97	2
3	Registered Nurses	16,022	16,579	532,639	32.13	3
4	Licensed Practical Nurses	60,579	62,804	1,728,843	27.53	4
5	CNAs & Orderlies	138,783	143,447	1,827,302	12.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	36,176	37,476	1,453,323	38.78	8
9	Activity Director	2,485	2,662	50,659	19.03	9
10	Activity Assistants	15,589	16,320	176,609	10.82	10
11	Social Service Workers	2,005	2,177	60,886	27.97	11
12	Dietician					12
13	Food Service Supervisor	1,556	1,581	36,780	23.26	13
14	Head Cook	4,243	4,417	70,938	16.06	14
15	Cook Helpers/Assistants	44,509	46,399	491,956	10.60	15
16	Dishwashers					16
17	Maintenance Workers	9,343	9,842	162,918	16.55	17
18	Housekeepers	36,868	38,306	410,330	10.71	18
19	Laundry	10,654	11,207	118,027	10.53	19
20	Administrator	936	1,000	51,124	51.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,881	12,435	246,153	19.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,913	2,029	34,635	17.07	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,886	3,094	47,528	15.36	31
32	Other Health Care(specify)	13,627	14,263	320,978	22.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	415,237	431,401	$ 8,034,900 *	$ 18.63	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	$ 25,265	1-3	35
36	Medical Director	O	42,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	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		55,285	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)		$ 122,550		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 NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HELEN LACEK	ADMINISTRATOR		$ 6,449
TAMRA MCDERMAND	ADMINISTRATOR		44,675
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,124

B. Administrative - Other

Description	Amount
	$
MANAGEMENT FEES	65,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 65,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		166,027
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 166,027

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 78,754
Unemployment Compensation Insurance		188,592
FICA Taxes		614,670
Employee Health Insurance		271,351
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		9,716
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)		$ 1,163,083

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	12,862
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	38,473
LICENSES/DUES/SUBSCRIPTIONS	14,610
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(37,973)
Yellow page advertising	(500)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,472

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

WINDSOR ESTATES NURSING & REHAB
Legal Fee Schedule
2017 COST REPORT

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
11/30/2017	LAW OFFICE OF LISTON & TSANTILS	2,253.85	
10/17/2017	O'HAGAN L	510.00	GENERAL LEGAL SERVICES
11/27/2017	O'HAGAN LLC	72.00	GENERAL LEGAL SERVICES
6/9/2017	ROBBINS SOLOMON	8,357.90	15895-00035 - MCALLISTER-COUNTRYSIDE HILLS ANNEXATION
6/9/2017	ROBBINS SOLOMON	271.25	15895-00032 - OAKWOOD ESTATES
1/30/2017	CHUBB GROUP OF INSURANCE COMPANY	604.50	DEFENSE COSTS
1/9/2017	CHUBB GROUP OF INSURANCE COMPANY	3,000.00	LITIGATION SUPPORT SERVICES
7/8/2017	CHUBB GROUP OF INSURANCE COMPANY	1,462.00	
7/8/2017	CHUBB GROUP OF INSURANCE COMPANY	473.00	DEFENSE COSTS
1/31/2017	KLEIN DUB & HOLLEB	356.25	
3/31/2017	KLEIN DUB & HOLLEB	1,565.39	
4/30/2017	KLEIN DUB & HOLLEB	1,187.50	
5/31/2017	KLEIN DUB & HOLLEB	3,109.14	
6/30/2017	KLEIN DUB & HOLLEB	237.50	
7/31/2017	KLEIN DUB & HOLLEB	1,781.25	
		25,242	

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

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

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

(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. $ 313,919
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