

		FOR BHF USE					

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0034652</u></p> <p><b>Facility Name:</b> <u>Windsor Park Manor</u></p> <p><b>Address:</b> <u>110 Windsor Park Dr</u> <u>Carol Stream</u> <u>60188</u>        Number City Zip Code</p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630) 510 - 5200</u> Fax # <u>(630) 682 - 4609</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/15/85</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Jeremy M. Brune, CPA</u> <b>Telephone Number:</b> <u>(779) 875 - 3979</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/16</u> to <u>01/31/17</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>         (Signed) _____          (Type or Print Name) _____          (Title) _____       </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>         (Signed) _____          (Date) _____          (Print Name and Title) <u>Jeremy M. Brune, CPA</u>  <u>CEO</u>          (Firm Name &amp; Address) <u>Jeremy Brune &amp; Associates, LLC</u>  <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u>          (Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u> (Firm Name & Address) <u>Jeremy Brune &amp; Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u> (Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u>
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652 Report Period Beginning: 02/01/16 Ending: 01/31/17

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	680	15,182	6,718	22,580	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	680	15,182	6,718	22,580	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.33%

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)  
N/A

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/15/85

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/15/85 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 36 and days of care provided 5,405

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/31/17 Fiscal Year: 01/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor # 0034652 Report Period Beginning: 02/01/16 Ending: 01/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	275,748	43,066	119,614	438,428		438,428		438,428		1
2	Food Purchase		291,593		291,593		291,593	(5,812)	285,781		2
3	Housekeeping	121,951	14,819	915	137,685		137,685		137,685		3
4	Laundry	16,209	9,838		26,047		26,047		26,047		4
5	Heat and Other Utilities			82,967	82,967		82,967		82,967		5
6	Maintenance	84,932	3,370	117,142	205,444		205,444	(1,665)	203,779		6
7	Other (specify):* See Supplemental										7
8	<b>TOTAL General Services</b>	498,840	362,686	320,638	1,182,164		1,182,164	(7,477)	1,174,687		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,426,459	105,580	79,025	2,611,064		2,611,064		2,611,064		10
10a	Therapy										10a
11	Activities	109,418		20,591	130,009		130,009		130,009		11
12	Social Services	169,231	31	14,152	183,414		183,414		183,414		12
13	CNA Training										13
14	Program Transportation	11,168			11,168		11,168	(1,115)	10,053		14
15	Other (specify):* See Supplemental										15
16	<b>TOTAL Health Care and Programs</b>	2,716,276	105,611	149,768	2,971,655		2,971,655	(1,115)	2,970,540		16
	<b>C. General Administration</b>										
17	Administrative	40,375		131,002	171,377		171,377		171,377		17
18	Directors Fees										18
19	Professional Services			676,292	676,292		676,292	(96,487)	579,805		19
20	Dues, Fees, Subscriptions & Promotions			43,023	43,023		43,023		43,023		20
21	Clerical & General Office Expenses	228,618	11,862	122,793	363,273		363,273	(98,863)	264,410		21
22	Employee Benefits & Payroll Taxes			990,456	990,456		990,456		990,456		22
23	Inservice Training & Education			2,906	2,906		2,906		2,906		23
24	Travel and Seminar			13,125	13,125		13,125		13,125		24
25	Other Admin. Staff Transportation			8,498	8,498		8,498	(3,982)	4,516		25
26	Insurance-Prop.Liab.Malpractice			70,466	70,466		70,466	(5,728)	64,738		26
27	Other (specify):* See Supplemental										27
28	<b>TOTAL General Administration</b>	268,993	11,862	2,058,561	2,339,416		2,339,416	(205,060)	2,134,356		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,484,109	480,159	2,528,967	6,493,235		6,493,235	(213,652)	6,279,583		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.



Facility Name &amp; ID Number

Windsor Park Manor

#0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			493,528	493,528		493,528		493,528		30
31	Amortization of Pre-Op. & Org.			1,819	1,819		1,819	(1,819)			31
32	Interest			60,721	60,721		60,721	(60,721)			32
33	Real Estate Taxes			55,713	55,713		55,713		55,713		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			30,604	30,604		30,604		30,604		35
36	Other (specify):* See Supplemental										36
37	<b>TOTAL Ownership</b>			642,385	642,385		642,385	(62,540)	579,845		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		306,074	894,604	1,200,678		1,200,678		1,200,678		39
40	Barber and Beauty Shops			17,272	17,272		17,272	(17,272)			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			196,884	196,884		196,884		196,884		42
43	Other (specify):* See Supplemental	10,029		61,267	71,296		71,296	(71,296)			43
44	<b>TOTAL Special Cost Centers</b>	10,029	306,074	1,170,027	1,486,130		1,486,130	(88,568)	1,397,562		44
	<b>GRAND TOTAL COST</b>										
45	(sum of lines 29, 37 & 44)	3,494,138	786,233	4,341,379	8,621,750		8,621,750	(364,760)	8,256,990		45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/16 - 01/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
<b>Line 36 - Other Capital Costs</b>				
				-
				-
				-
				-
				-
				-
				-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 43 - Other Special Cost Centers</b>				
Marketing / Fundraising	10,029		61,267	71,296
				-
				-
				-
				-
				-
				-
<b>Sub-Total</b>	<u>10,029</u>	<u>-</u>	<u>61,267</u>	<u>71,296</u>

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,812)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,046)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(60,721)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,991)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,476)	21		24
25	Fund Raising, Advertising and Promotional	(71,296)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(31,931)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (268,273)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(96,487)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (96,487)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (364,760)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

Windsor Park Manor

ID# 0034652

Report Period Beginning: 02/01/16

Ending: 01/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Barber and Beauty Shop Revenue	\$ (17,272)	40	1
2	Guest Apartment Revenue	(1,500)	06	2
3	Transportation Revenue	(1,115)	14	3
4	Maintenance Revenue	(165)	06	4
5	Other Service Revenue	(350)	21	5
6	Directors and Officers Insurance	(5,728)	26	6
7	Amortized Debts Costs	(1,819)	31	7
8	Non-Allowable Travel	(3,982)	25	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
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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	<b>Total</b>	(31,931)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,812)	0	0	0	0	0	0	0	0	0	0	(5,812)	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	(1,665)	0	0	0	0	0	0	0	0	0	0	(1,665)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,477)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,477)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(1,115)	0	0	0	0	0	0	0	0	0	0	(1,115)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,115)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,115)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(96,487)	0	0	0	0	0	0	0	0	0	(96,487)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(98,863)	0	0	0	0	0	0	0	0	0	0	(98,863)	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	(3,982)	0	0	0	0	0	0	0	0	0	0	(3,982)	25
26	Insurance-Prop.Liab.Malpractice	(5,728)	0	0	0	0	0	0	0	0	0	0	(5,728)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(108,573)</b>	<b>(96,487)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(205,060)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(117,165)</b>	<b>(96,487)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(213,652)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(1,819)	0	0	0	0	0	0	0	0	0	0	(1,819)	31
32	Interest	(60,721)	0	0	0	0	0	0	0	0	0	0	(60,721)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(62,540)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(62,540)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(17,272)	0	0	0	0	0	0	0	0	0	0	(17,272)	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):*	(71,296)	0	0	0	0	0	0	0	0	0	0	(71,296)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(88,568)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(88,568)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(268,273)</b>	<b>(96,487)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(364,760)</b>	<b>45</b>

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
Covenant Retirement Communities, Inc.	100.00%	See Page 6 - Supplemental				

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	19	Home Office	\$ 621,568	Covenant Retirement Communities, Inc.	100.00%	\$ 525,081	\$ (96,487)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 621,568			\$ 525,081	\$ *	(96,487)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

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	Non-Profit Board of Directors							2
3								3
4	Jon Aagaard, MD		Brandel Manor	Turlock , CA	Covenant Ministries			4
5	Pamela Christensen		Covenant Health Care Ctr - Northbrook	Northbrook, IL	of Benevolence	Chicago, IL	Corporate Office	5
6	Kara Davis		Colonial Acres Healthcare	Golden Valley, MN	Covenant Retirement			6
7	Mark Eastburg		Covenant Shores HC	Mercer Island, WA	Communities	Skokie, IL	Home Office	7
8	Jim Elving		Covenant Village Care Center	Plantation, FL	Brandel Manor	Turlock, CA	Asst. Living	8
9	Marc Espinosa		Covenant Village of Turlock	Turlock, CA	Covenant Village			9
10	Rhoda Friesen		Covenant Village of Colorado	Westminister, CO	of Northbrook	Northbrook, IL	Asst. & Ind. Living	10
11	Thomas Heywood		Covenant Health Care Ctr - Batavia	Batavia, IL	Covenant Villae			11
12	Donald Hodgkinson		Mount Miguel Covenant Village	Spring Valley, CA	of Golden Valley	Golden Valley, MN	Asst. & Ind. Living	12
13	Kathy Holmgren		The Samarkand	Santa Barbara, CA	Covenant Shores	Mercer Island, WA	Asst. & Ind. Living	13
14	Jody Holt		Windsor Park Manor	Carol Stream, IL	Covenant Village			14
15	Scott Macdonald		Covenant Village of Great Lakes	Grand Rapids, MI	of Florida	Plantation, FL	Asst. & Ind. Living	15
16	Matthew Manlove				Covenant Village			16
17	Dale Rinard				of Turlock	Turlock, CA	Asst. & Ind. Living	17
18	Marlene Stante				Covenant Village			18
19	Anne Vinding				of Colorado	Westminister, CO	Asst. & Ind. Living	19
20					The Holmstad	Batavia, IL	Asst. & Ind. Living	20
21					Mount Miguel			21
22					Covenant Village	Spring Valley, CA	Asst. & Ind. Living	22
23					The Samarkand	Santa Barbara, CA	Asst. & Ind. Living	23
24					Windsor Park Manor	Carol Stream, IL	Asst. & Ind. Living	24
25					Covenant Village			25
26					of Great Lakes	Grand Rapids, MI	Asst. & Ind. Living	26
27					Covenant Home			27
28					of Chicago	Chicago, IL	Supportive Living	28
29					Est. of Windsor Park	Carol Stream, IL	Ind. Living	29
30					Cov. Care at Home		Home Health	30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor # 0034652 Report Period Beginning: 02/01/16 Ending: 01/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2	N/A									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending: 01/31/17

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 Covenant Retirement Communities, Inc.  
 Street Address 5700 Old Orchard Road  
 City / State / Zip Code Skokie, Illinois 60077  
 Phone Number ( 773) 878 - 2294  
 Fax Number ( 773) 878 - 2289

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	19	Home Office	Operating Expenses	318,937,000	31	\$ 20,891,163	\$ 6,611,595	8,016,199	\$ 525,081	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					\$ 20,891,163	\$ 6,611,595		\$ 525,081	25

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number **Windsor Park Manor**

# **0034652**

Report Period Beginning:

**02/01/16**

Ending:

**01/31/17**

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<b>43,874</b>	<b>1</b>
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.)		\$	<b>50,908</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>7,034</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,679</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>55,713</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012		<b>8</b>	
	2013		<b>9</b>	
	2014	<b>42,993</b>	<b>10</b>	
	2015	<b>44,770</b>	<b>11</b>	
	2016	<b>50,908</b>	<b>12</b>	
<b>Windsor Park Manor receives an allocation of the real estate tax bill that is assigned for the entire campus.</b>				

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Windsor Park Manor COUNTY DuPage  
 FACILITY IDPH LICENSE NUMBER 0034652  
 CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA  
 TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

**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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02 - 31 - 405 - 019</u>	<u>Nursing Facility</u>	\$ <u>300,022.76</u>	\$ <u>50,908.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>300,022.76</u></u>	\$ <u><u>50,908.00</u></u>

**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?  X  YES   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 Park Manor

# 0034652

Report Period Beginning:

02/01/16 Ending:

01/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,278 B. General Construction Type: Exterior Brick Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 3 is shaded and labeled 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	1988	1988	\$ 3,307,486	\$		\$	\$	\$	4
5		2003	2003	3,876,108						5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1988	370,354						9
10	Various		2006	9,002						10
11	Various		2007	180,149						11
12	Various		2008	73,476						12
13	Various		2009	22,627						13
14	Various		2010	168,603						14
15	Various		2011	110,404						15
16	Various		2012	21,307						16
17	Various		2013	213,061						17
18	HCC - Sidewalk Section Repair		2014	3,600						18
19	HCC - Storm Sewer Repair		2014	3,600						19
20	HCC - Parking Lot Asphalt (West Parking Lot)		2015	150,955						20
21	HCC - Windows (Common Areas)		2015	7,083						21
22	HCC - Doors (East Exit)		2015	10,550						22
23	HCC - Survey Matters (West Wing 2)		2015	19,695						23
24	HCC - Flooring, Paint, Electrical (Beauty Shop to Offices Conversion)		2016	14,275						24
25	HCC - Parking Lot Asphalt (South and East Parking Lots)		2016	56,175						25
26	HCC - 6 Street Lights (East Parking Lot)		2016	17,327						26
27	HCC - 2 Boiler Circulation Pumps (Boiler Room)		2016	15,538						27
28	HCC - AC Units (Servery)		2016	28,454						28
29	HCC - Door Assemblies and Remote Access (Main Entrance)		2016	3,505						29
30	HCC - PTAC Units (Resident Rooms 121, 122, 123, 127, 129, 130, 182,183)		2016	25,728						30
31	HCC - Bed Lights, Faucet, Grab Bars, Plumbing Fixtures, Painting, Tile,									31
32	Flooring, Vanity, Vinyl Base, Windos, Blinds, Doors, HVAC Unit,									32
33	Resident Rooms (121, 122, 123)		2016	72,340						33
34	Resident Rooms (124, 125, 126, 127, 128)		2017	131,410						34
35	HCC - Doors (Resident Rooms 121, 122, 123, 124, 125, 126, 127, 128, 129)		2017	11,697						35
36	HCC - Wanderguard System		2017	10,973						36

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

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

See Page 12A, Line 70 for total  
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68	Depreciation: Windsor Park Manor		493,528		493,528		5,961,495	68
69								69
70	TOTAL (lines 4 thru 69)	\$	8,935,482	\$	493,528	\$	5,961,495	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,617,937	\$	\$	\$		\$	71
72	Current Year Purchases	68,496						72
73	Fully Depreciated Assets							73
74	Disposals	(10,517)						74
75	TOTALS	\$ 1,675,916	\$	\$	\$		\$	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		1997	\$ 2,188	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 2,188	\$	\$	\$		\$	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)	\$ 10,613,586	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 493,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 493,528	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,961,495	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning: 02/01/16

Ending: 01/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. [ ] YES [ ] NO

Table with 8 columns: Line, Description, 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option\*, 7. Rows include Original Building, Additions, See Suppl, and TOTAL.

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows for 2018, 2019, 2020.

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy: [ ] YES [ ] NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

[ ] YES [ ] NO

16. Rental Amount for movable equipment: \$ 30,604 Description:

See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: Line, 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5. Rows 17-21.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT



**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

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

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	332,700	\$		\$	332,700	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				41,180				41,180	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				448,054				448,054	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					234,294			234,294	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						71,780			71,780	12
13	Other (specify): See Supplemental	39 - 03						72,670			72,670	13
14	TOTAL			\$		\$	894,604	\$	306,074	\$	1,200,678	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

**Windsor Park Manor  
 Medicaid Cost Report  
 02/01/16 - 01/31/17**

**Page 16 Supplemental Schedule**

Description	Salaries		Supplies		Other		Total
Medical Supplies			67,591				67,591
Therapy Supplies			4,189				4,189
Laboratory and Radiology					72,670		72,670
							-
							-
							-
							-
							-
							-
							-
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							-
							-
							-
<b>Total</b>	-		71,780		72,670		144,450

Facility Name & ID Number Windsor Park Manor  
 XV. BALANCE SHEET - Unrestricted Operating Fund.

# 0034652  
 As of 01/31/17

Report Period Beginning: 02/01/16  
 (last day of reporting year)

Ending: 01/31/17

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>73,792</u> )	966,447		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,229		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 969,676	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,638,300		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,977,746		16
17	Accumulated Depreciation (book methods)	(5,961,495)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,628		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(14,597)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	14,946,041		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 19,606,623	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 20,576,299	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 269,612	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,402		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,435		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,679		32
33	Accrued Interest Payable	3,036		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 633,164	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,096,778		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Supplemental Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,096,778	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,729,942	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 18,846,357	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 20,576,299	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/16 - 01/31/17

Page 17 Supplemental Schedule

Description	Operating	Building	Total
<b>Line 9 - Other Current Assets</b>			
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 23 - Long Term Assets</b>			
Construction in Progress	12,772		12,772
Intercompany Receivable	13,117,849		13,117,849
Endowment Reserve Fund(s)	1,798,355		1,798,355
Debt Service Reserve Fund(s)	17,065		17,065
Capital Reserve Fund(s)	-		-
<b>Sub-Total</b>	<u>14,946,041</u>	<u>-</u>	<u>14,946,041</u>
<b>Line 36 - Other Current Liability</b>			
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 43 - Long term Liabilities</b>			
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 16,391,684	1
2	Restatements (describe):		2
3	<b>PY CR - Perm. Restricted Net Assets Misclassified</b>	1,785,597	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 18,177,281	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	669,076	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 669,076	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 18,846,357	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,688,507	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,688,507	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,781	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 179,781	8
<b>C. Other Operating Revenue</b>			
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	17,230	13
14	Non-Patient Meals	5,812	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,500	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 24,542	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	5,649	24
25	Interest and Other Investment Income***	390,717	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 396,366	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>	1,630	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,630	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,290,826	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,182,164	31
32	Health Care	2,971,655	32
33	General Administration	2,339,416	33
<b>B. Capital Expense</b>			
34	Ownership	642,385	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,289,246	35
36	Provider Participation Fee	196,884	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,621,750	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	669,076	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 669,076	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 85,419	44
45	Private Pay - Net Inpatient Revenue	5,049,677	45
46	Medicare - Net Inpatient Revenue	2,909,933	46
47	Other-(specify) <a href="#">Insurance - Net Inpatient Revenue</a>	642,608	47
48	Other-(specify) <a href="#">Hospice - Net Inpatient Revenue</a>	870	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,688,507	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/16

Ending:

01/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,649	1,998	\$ 103,117	\$ 51.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,401	27,776	975,048	35.10	3
4	Licensed Practical Nurses	9,265	10,135	268,958	26.54	4
5	CNAs & Orderlies	57,168	64,205	966,139	15.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,582	2,813	62,477	22.21	9
10	Activity Assistants	3,280	3,515	46,941	13.35	10
11	Social Service Workers	5,480	5,938	146,911	24.74	11
12	Dietician					12
13	Food Service Supervisor	436	480	10,138	21.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,522	22,075	265,610	12.03	15
16	Dishwashers					16
17	Maintenance Workers	3,605	4,042	84,932	21.01	17
18	Housekeepers	9,003	10,124	121,951	12.05	18
19	Laundry	1,263	1,483	16,209	10.93	19
20	Administrator	254	586	40,375	68.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,813	9,625	228,618	23.75	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	2,054	2,312	59,338	25.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,047	3,302	97,376	29.49	33
34	TOTAL (lines 1 - 33)	153,822	170,409	\$ 3,494,138 *	\$ 20.50	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 2,476	01 - 03	35
36	Medical Director	36,000	09 - 03	36
37	Medical Records Consultant	915	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,656	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	780	11 - 03	44
45	Social Service Consultant	1,341	12 - 03	45
46	Other(specify)			46
47	See Supplemental Schedule	170,674	Various	47
48				48
49	TOTAL (lines 35 - 48)	\$ 216,842		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

\*\* See instructions.







**Windsor Park Manor  
Medicaid Cost Report  
02/01/16 - 01/31/17**

**Page 21 Supplemental Schedule - Seminar**

<b>Vendor</b>	<b>Session Title</b>	<b>Seminar Date</b>	<b>Location</b>	<b>Attendee</b>	<b>Amount</b>	<b>Non-Allowable</b>	<b>Allowable</b>
Life Services Network	Authorized Electronic monitoring	02/09/16	Carol Stream, IL	J. Bernadyn	99		99
Life Services Network	Authorized Electronic monitoring	02/09/16	Carol Stream, IL	N. James	99		99
Hyatt Regency	Pastoral & Chaplain Ministry	02/29/16	Chicago, IL	T. Peterson	162		162
5 Roses -Dining	Pastoral & Chaplain Ministry	02/29/16	Chicago, IL	T. Peterson	3		3
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Carol Stream, IL	B. Zacharius	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	K. Eddins	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	T. Foster	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	N. James	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	M. Lindsey	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	S. Mildrag	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	S. Sabin	194		194
NIU Outreach	Leading Age Annual Meeting & Exhibition	04/05 - 07/16	Schaumburg, IL	P. Sena	194		194
Fred Pryor Career Track	Excel spreadsheet training	04/26/16	Elk Grove Vllg, IL	S. Kustus	128		128
Pathway Health Services	RAC -CT certification	04/30/16	Westmont, IL.	S. Mildrag	550		550
Cross Country Education	Early Dementia Therapeutic outcomes	05/12/16	Naperville, IL	N. Dumele	200		200
Cross Country Education	Early Dementia Therapeutic outcomes	05/12/16	Naperville, IL	S. Mildrag	200		200
Fred Pryor Career Track	CB/ How to communicate with tact	06/13/16	Elk Grove Vllg, IL	K. Eddins	299		299
Health Information Network	Medicare Payment Reform	08/04/16	Schaumburg, IL	B. Zacharius	199		199
Health Information Network	Medicare Payment Reform	08/04/16	Schaumburg, IL	S. Mildrag	199		199
Health Information Network	New MDS /RAI	09/21/16	Schaumburg, IL	S. Mildrag	20		20
Leading Age	Implementation of the New GG Section	09/26/16	Carol Stream, IL	B. Zacharius	99		99
PESI	Joint replacement	09/27/16	Downers Grve, IL	B. Zacharius	200		200
PESI	Joint replacement	09/27/16	Downers Grve, IL	K. Eddins	200		200
PESI	Joint replacement	09/27/16	Downers Grve, IL	D. Wolski	200		200
North Shore University	Dementia	09/30/16	Glencoe, IL	S. Sabin	25		25
North Shore University	Dementia	09/30/16	Glencoe, IL	N. Dumele	25		25
Health Information Network	Survey Enforcement-New LifeSafety Code	11/29/16	Schaumburg, IL	R. Lanzerotti	199		199
Health Information Network	Survey Enforcement-New LifeSafety Code	11/29/16	Schaumburg, IL	J. Bernadyn	199		199
Health Information Network	Survey Enforcement-New LifeSafety Code	11/29/16	Schaumburg, IL	J. Bernadyn	(154)		(154)
Relias	On-Line Training Software	Various	Various	Various	8,421		8,421
<b>Total</b>					<b>13,125</b>	<b>-</b>	<b>13,125</b>

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Leading Age
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,070 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 196,884  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' PREPARATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,812
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
  - d. Have vehicle usage logs been maintained? Yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - 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? Yes  
Firm Name: Plante & Moran, PLLC
- (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