FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0049502

Facility Name: WINDSOR ESTATES NURSING & REHAB

Address: 18300 S. LAVERGNE (Number) COUNTRY CLUB HILLS (City) 60478 (Zip Code)

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

- ☐ VOLUNTARY,NON-PROFIT
  - ☐ Charitable Corp.
  - ☐ Trust
- IRS Exemption Code
- ☐ PROPRIETARY
  - ☐ Individual
  - ☐ Partnership
  - ☐ Corporation
  - ☐ "Sub-S" Corp.
  - ☐ Limited Liability Co.
  - ☐ Trust
  - ☐ Other
- ☐ GOVERNMENTAL
  - ☐ State
  - ☐ County
  - ☐ Other

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA **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 01/01/2018 to 12/31/2018 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)
(Title)

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-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: 01/01/2018 Ending: 12/31/2018

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	33,073	5,010	16,277	54,360	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,073	5,010	16,277	54,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.47%

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/ 01 /08

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 14,382

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	642,905	76,869	26,580	746,354		746,354		746,354			1
2	Food Purchase		369,695		369,695		369,695		369,695			2
3	Housekeeping	471,840	65,838		537,678		537,678		537,678			3
4	Laundry	116,726	24,038	3,684	144,448		144,448		144,448			4
5	Heat and Other Utilities			277,311	277,311		277,311		277,311			5
6	Maintenance	170,530	37,117	92,312	299,959		299,959		299,959			6
7	Other (specify):*			30,769	30,769		30,769		30,769			7
8	**TOTAL General Services**	1,402,001	573,557	430,656	2,406,214		2,406,214		2,406,214			8
	B. Health Care and Programs											
9	Medical Director			27,500	27,500		27,500		27,500			9
10	Nursing and Medical Records	5,212,503	301,799	28,950	5,543,252		5,543,252		5,543,252			10
10a	Therapy	1,389,808	8,295	2,710	1,400,813		1,400,813		1,400,813			10a
11	Activities	203,638	40,021		243,659		243,659		243,659			11
12	Social Services	56,040			56,040		56,040		56,040			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	36,104			36,104		36,104		36,104			15
16	**TOTAL Health Care and Programs**	6,898,093	350,115	59,160	7,307,368		7,307,368		7,307,368			16
	C. General Administration											
17	Administrative	76,050			76,050		76,050	59,933	135,983			17
18	Directors Fees											18
19	Professional Services			324,882	324,882		324,882		324,882			19
20	Dues, Fees, Subscriptions & Promotions			45,293	45,293		45,293	(25,524)	19,769			20
21	Clerical & General Office Expenses	377,348	79,244	394,111	850,703		850,703	(301,701)	549,002			21
22	Employee Benefits & Payroll Taxes			1,219,002	1,219,002		1,219,002		1,219,002			22
23	Inservice Training & Education			8,715	8,715		8,715		8,715			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			15,210	15,210		15,210		15,210			25
26	Insurance-Prop.Liab.Malpractice			367,088	367,088		367,088		367,088			26
27	Other (specify):*			412,172	412,172		412,172	(342,814)	69,358			27
28	**TOTAL General Administration**	453,398	79,244	2,786,473	3,319,115		3,319,115	(610,106)	2,709,009			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,753,492	1,002,916	3,276,289	13,032,697		13,032,697	(610,106)	12,422,591			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: 01/01/2018** **Ending: 12/31/2018**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	24,279	
	REPAIRS & MAINTENANCE		2,301	
				26,580
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,684	
				3,684
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		63,654	
	ELECTRICITY		140,919	
	WATER		67,634	
	CABLE TV - LOBBY		5,104	
				277,311
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		33,887	
	PAINTING & DECORATING		2,214	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		14,547	
	ELEVATOR MAINTENANCE & REPAIR		23,776	
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		7,551	
	FIRE SERVICE		10,337	
				92,312
7	**OTHER**			
	SCAVENGER		30,769	
	SECURITY SERVICE			
				30,769
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	27,500	27,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES		15,550	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	2,025	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	11,375	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2		
				28,950
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	2,710	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				2,710
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2		
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	SOCIAL WORKER	XVIII B 45-2		
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB **#0049502** **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION			
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B		0
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	119,088	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	205,794	
				324,882
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	4,589	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,735	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F		
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F		
	LICENSES & PERMITS	XIX F	10,177	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	4,802	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,200	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	4,790	
	PATIENT BACKGROUND CHECKS	XIX F		
				45,293
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		30,502	
	EQUIPMENT REPAIR & MAINTENANCE			
	OUTSIDE CLERICAL SERVICES		282,289	
	PENALTIES / OVERDRAFT CHARGES	VI 18	36,190	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS		2,724	
	TELEPHONE		42,406	
	MESSENGER SERVICE			
				394,111

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	669,000	
	UNEMPLOYMENT COMPENSATION	XIX D	123,693	
	WORKERS COMPENSATION INSURANC	XIX D	142,573	
	HOSPITALIZATION INSURANCE	XIX D	279,899	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,555	
	EMPLOYEE PHYSICAL EXAMS	XIX D	282	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				1,219,002
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		8,715	
				8,715
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G		
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,210	
				15,210
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		367,088	
				367,088
27	**OTHER**			
	BAD DEBTS	VI 24	412,172	
				412,172

GRAND TOTAL COLUMN 3 OTHER **3,276,289**

WINDSOR ESTATES NURSING & REHAB
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	369,695
LESS SALES TAX	0
NET FOOD	369,695
TOTAL PATIENT CENSUS	54,360
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	163,080
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	73,000
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	163,080
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	163,080
NET FOOD	369,695
DIVIDE TOTAL MEALS/YEAR	163,080
COST PER MEAL	2.27
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFIC	**0**

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB #0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			73,741	73,741		73,741	922,452	996,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,001	111,001		111,001	2,320,837	2,431,838			32
33	Real Estate Taxes			461,208	461,208		461,208		461,208			33
34	Rent-Facility & Grounds			2,340,000	2,340,000		2,340,000	(2,340,000)				34
35	Rent-Equipment & Vehicles			111,983	111,983		111,983		111,983			35
36	Other (specify):* STORAGE											36
37	**TOTAL Ownership**			3,097,933	3,097,933		3,097,933	903,289	4,001,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		460,261		460,261		460,261		460,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			333,137	333,137		333,137		333,137			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		460,261	333,137	793,398		793,398		793,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,753,492	1,463,177	6,707,359	16,924,028		16,924,028	293,183	17,217,211			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: 01/01/2018 Ending: 12/31/2018

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 Refer-ence	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	23,660	30		9
10	Interest and Other Investment Income	(2,967)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(9,907)	32		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	(36,190)	21		18
19	Entertainment	(4,589)	20		19
20	Contributions	(7,200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(361,447)	27		24
25	Fund Raising, Advertising and Promotional	(13,735)	20		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	(157,326)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (569,701)		$	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)	862,884		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 862,884		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 293,183		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (30,502)	21	1
2	MARKETING SALARIES	(126,824)	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**	(157,326)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	59,933	0	0	0	0	0	0	0	0	59,933	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25,524)	0	0	0	0	0	0	0	0	0	0	(25,524)	20
21	Clerical & General Office Expenses	(193,516)	0	(108,185)	0	0	0	0	0	0	0	0	(301,701)	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):*	(361,447)	0	18,633	0	0	0	0	0	0	0	0	(342,814)	27
28	**TOTAL General Administration**	(580,487)	0	(29,619)	0	0	0	0	0	0	0	0	(610,106)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(580,487)	0	(29,619)	0	0	0	0	0	0	0	0	(610,106)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	23,660	898,792	0	0	0	0	0	0	0	0	0	922,452	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,874)	2,333,711	0	0	0	0	0	0	0	0	0	2,320,837	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(2,340,000)	0	0	0	0	0	0	0	0	0	(2,340,000)	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	10,786	892,503	0	0	0	0	0	0	0	0	0	903,289	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)	(569,701)	892,503	(29,619)	0	0	0	0	0	0	0	0	293,183	45

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	47.5	OAKRIDGE HEALTHCARE CENTER ,LLC	HILLSIDE IL.	MCALLISTER		
DONNA ATKIN	47.5			PROPERTY , LLC	TINLEY PARK IL	REAL ESTATE
HELEN LACEK	5.0	Abington of Glenview Nursing & Rehab	GLENVIEW , IL	OAKRIDGE		
				PROPERTY , LLC	HILLSIDE	REAL ESTATE
				ABINGTON OF		
				GLENVIEW ,PROP	GLENVIEW	REAL ESTATE
				INNOVATIVE MGT	MORTON GROVE	BOOK / MANAGE

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	$ 2,340,000	MCALLISTER PROPERTY , LLC		$	$ (2,340,000)	1
2	V	30	DEPRECIATION				898,792	898,792	2
3	V	32	INTEREST				1,984,814	1,984,814	3
4	V	32	AMORT OF LOAN COSTS				348,897	348,897	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			$ 2,340,000			$ 3,232,503	$ * 892,503	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: 01/01/2018 Ending: 12/31/2018

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	$ 282,289	INNOVATIVE MANAGEMENT		$	$ (282,289)	15
16	V	17	Administration- Eli Atkin				15,979	15,979	16
17	V	17	Administration- Joel Atkin				9,507	9,507	17
18	V	17	Admiinistration- Helen Lacek				34,447	34,447	18
19	V	21	ADMINISTRATOR- Tzvi Atkin				23,137	23,137	19
20	V	21	Clerical Salaries- Corey Fuchs				9,685	9,685	20
21	V	21	Clerical Salaries				141,282	141,282	21
22	V	27	Payroll Taxes				18,633	18,633	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 282,289			$ 252,670	$ * (29,619)	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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TZVI (STEVE) ATKIN	ADMINISTRATOR	Administration		see attached	see attached		SALARY	$ 23,137	17-7	1
2						40					2
3	JOEL ATKIN	OTHER ADMIN	Administration ans		see attached	see attached		SALARY	9,507	17-7	3
4			Financial Servise			8					4
5	ELISHA ATKIN	ADMINISTRATION	Adiministator		see attached	see attached		SALARY	15,979	17-7	5
6						20					6
7	JOHN LACEK	MAINTENANCE	MAINTENANCE					SALARY	32,329	6-1	7
8											8
9	COREY FUCHS	CLERICAL	Bookkeeping		see attached	see attached		SALARY	9,685	21-7	9
10						10					10
11	HELEN LACEK	ADMINISTRATION	ADMINISTRATIC	5.00	0	3		SALARY	34,447	17-7	11
12								SALARY			12
13								TOTAL	$ 125,084		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: 01/01/2018 Ending: 2/31/2018

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	Administration- Eli Atkin	Available Beds	369,015	7	$ 80,774	$ 80,774	73,000	$ 15,979	1
2	17	Administration- Joel Atkin	Available Beds	369,015	7	48,060	48,060	73,000	9,507	2
3	17	Admiinistration- Helen Lacek	Available Beds	369,015	7	174,128	174,128	73,000	34,447	3
4	21	ADMINISTRATOR- Tzvi Atkin	Available Beds	369,015	7	116,960	116,960	73,000	23,137	4
5	21	Clerical Salaries- Corey Fuchs	Available Beds	369,015	7	48,959	48,959	73,000	9,685	5
6	21	Clerical Salaries	Available Beds	369,015	7	714,181	714,181	73,000	141,282	6
7	27	Payroll Taxes	Available Beds	369,015	7	94,189		73,000	18,633	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					$ 1,277,251	$ 1,183,062		$ 252,670	25

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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							$	$			$	1
2												2
3												3
4	TPC										907	4
5	JACK ATKIN										9,000	5
	Working Capital											
6	HUNTINGTON BANK		X	WORKING CAPITAL	REVOLV					PRIME +	37,811	6
7	BANK LEUMI		X	WORKING CAPITAL	REVOLV	6/26/18		1,850,833	6/26/19	PRIME +	52,385	7
8	FIRST INSURANCE FUND		X	INSURANCE POLICIES FIN							10,898	8
9	TOTAL Facility Related						$	$ 1,850,833			$ 111,001	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,850,833			$ 111,001	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: 01/01/2018 Ending: 12/31/2018

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	FIRST MERIT BANK		X	MORTGAGE	$133,422.64	3/31/14	$ 23,947,000	$	6/26/18	0.0428	$ 968,483	1
2	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		01/15/16	336,808				292,248	2
3	ABILITY INSURANCE	X		2ND MORTGAGE	INT ONLY	3/31/14	5,625,000	5,625,000			454,250	3
4	SUSQUEHANNA FINANCE		X	WASHER & DRYER			43,948	20,277	02/09/21	0.0625	2,274	4
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		06/26/18	339,891	283,242	06/26/21		56,649	5
	Working Capital											
6	BANK LEUMI		X	MORTGAGE	INT ONLY	06/26/18	27,120,000	27,120,000	06/26/21	0.0625	544,012	6
7	BANK LEUMI		X	REPAIR AND MAINT FUNDI	INT ONLY	06/26/18	630,000	630,000	06/26/21	0.0625	15,795	7
8												8
9	TOTAL Facility Related				$133,422.64		$ 58,042,647	$ 33,678,519			$ 2,333,711	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 58,042,647	$ 33,678,519			$ 2,333,711	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 693,683	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.)		$ 537,542	2
3. Under or (over) accrual (line 2 minus line 1).		$ (156,141)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 617,349	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.		$ 461,208	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	313,648	8
	2014	534,652	9
	2015	532,291	10
	2016	346,979	11
	2017	404,093	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 KATHLEEN MCNAMARA

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-004-0000	NURSING HOME	$ 102,572.11	$ 102,572.11
2.	28-33-403-005-0000	NURSING HOME	$ 143,699.08	$ 143,699.08
3.	28-33-403-044-0000	NURSING HOME	$ 157,822.18	$ 157,822.18
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 404,093.37	$ 404,093.37

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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? [ ] (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 [ ] 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: 01/01/2018 Ending: 12/31/2018

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	$	$ 1,228,495	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASPHALT PAVING			2016	349,559	11,652	15	23,304	11,652	55,347	9
10	CONCRETE PAVING			2016	161,155	5,372	15	10,744	5,372	25,517	10
11	LANDSCAPING			2016	458,622	15,287	15	30,575	15,288	72,616	11
12	LIGHTING SITE			2016	108,095	3,603	15	7,206	3,603	17,115	12
13	MONUMENT SIGN			2016	20,549	685	15	1,370	685	3,254	13
14	SITE SIGNAGE			2016	19,109	637	15	1,274	637	3,025	14
15	STORM WATER SYSTEM			2016	130,325	4,344	15	8,688	4,344	20,634	15
16	LANDSCAPING			2016	24,325	811	15	1,622	811	3,650	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
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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: 01/01/2018 Ending: 12/31/2018

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	$ 1,429,653	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: 01/01/2018 Ending: 12/31/2018

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	$ 369,409	$ 37,256	$ 36,941	$ (315)	10 YRS	$ 89,552	71
72	Current Year Purchases	34,981	34,981	1,749	(33,232)	10 YRS	1,749	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	3,532,294	339,100	353,229	14,129	10 YRS	883,073	74
75	TOTALS	$ 3,936,684	$ 411,337	$ 391,919	$ (19,418)		$ 974,374	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)	$ 25,756,411	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 971,029	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 994,689	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,660	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,411,677	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: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 111,983 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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

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				395,781		395,781	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					64,480		64,480	13
14	TOTAL			$		$	$ 460,261		$ 460,261	14

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

STATE OF ILLINOIS

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 14,071	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 410,000)	8,519,206		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	208,571		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,741,848	$	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	590,113		16
17	Accumulated Depreciation (book methods)	(536,014)		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 FR PROPCO	381,245		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 439,861	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,181,709	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,460,475	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,850,831		29
30	Accrued Salaries Payable	410,858		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,619		31
32	Accrued Real Estate Taxes(Sch.IX-B)	617,349		32
33	Accrued Interest Payable	9,175		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE FR AFFLIATES	4,449,987		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,858,294	$	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)**	$ 9,858,294	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (676,585)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,181,709	$	48

*(See instructions.)

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (832,252)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (832,252)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	119,369	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe) CAPITAL CONTRIBUTED	36,298	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 155,667	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)**	$ (676,585)	24 *

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 16,742,217	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,742,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	309,682	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 309,682	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***	2,967	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,967	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OUT OF PERIOD EXPENSES	(11,469)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (11,469)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,043,397	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,406,214	31
32	Health Care	7,307,368	32
33	General Administration	3,319,115	33
	B. Capital Expense		
34	Ownership	3,097,933	34
	C. Ancillary Expense		
35	Special Cost Centers	460,261	35
36	Provider Participation Fee	333,137	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,924,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	119,369	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 119,369	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,281,153	44
45	Private Pay - Net Inpatient Revenue	1,438,590	45
46	Medicare - Net Inpatient Revenue	8,182,859	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	839,615	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,742,217	49

TAX RETURN NOT FILED AS OF COST REPORT FILING DATE

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

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

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

Facility Name & ID Number WINDSOR ESTATES NURSING & REHAB # 0049502 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,034	2,126	$ 105,389	$ 49.57	1
2	Assistant Director of Nursing	2,506	2,605	102,133	39.21	2
3	Registered Nurses	15,882	16,641	555,862	33.40	3
4	Licensed Practical Nurses	63,935	66,995	1,842,502	27.50	4
5	CNAs & Orderlies	157,822	162,948	2,232,019	13.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	33,330	34,627	1,389,808	40.14	8
9	Activity Director	2,027	2,078	35,331	17.00	9
10	Activity Assistants	12,615	13,669	168,307	12.31	10
11	Social Service Workers	2,037	2,119	56,040	26.45	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,061	48,660	23.61	13
14	Head Cook	6,084	6,329	94,181	14.88	14
15	Cook Helpers/Assistants	38,313	40,122	444,319	11.07	15
16	Dishwashers	3,764	4,046	55,745	13.78	16
17	Maintenance Workers	9,226	9,903	170,530	17.22	17
18	Housekeepers	40,346	42,023	471,840	11.23	18
19	Laundry	10,472	10,951	116,726	10.66	19
20	Administrator	42	51	2,837	55.63	20
21	Assistant Administrator	1,464	1,520	73,213	48.17	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,579	17,445	377,348	21.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,037	2,086	36,104	17.31	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	15,595	16,381	374,598	22.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	438,075	456,726	$ 8,753,492 *	$ 19.17	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	$ 24,279	1-3	35
36	Medical Director	O	27,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,025	10-3	38
39	Pharmacist Consultant	H	11,375	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		2,710	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)		$ 67,889		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: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TZVI ATKIN	ADMINISTRATOR	0	$ 2,837
CECILE CASTRO	ASST . ADMINISTRATOR	0	73,213
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,050

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED		324,882
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 324,882

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,573
Unemployment Compensation Insurance	123,693
FICA Taxes	669,000
Employee Health Insurance	279,899
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,555
EMPLOYEE PHYSICAL EXAMS	282
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,219,002

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	4,790
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	7,200
MARKETING/ADV/PROMO	23,126
LICENSES/DUES/SUBSCRIPTIONS	10,177
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(7,200)
Less: Public Relations Expense	(4,589)
Non-allowable advertising	(13,735)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,769

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)	$

**See instructions.

WINDSOR ESTATES NURSING & REHAB
LEGAL EXPENSES
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST
2/28/18	COHEN , SALK, HUVARD		Construction Litigation	15,000.00
11/30/18	COHEN , SALK, HUVARD		Construction Litigation	10,000.00
4/11/18	MUCH SHELIST		Medicare Application	1,000.00
5/1/18	MUCH SHELIST		Medicare Application	100.00
6/1/18	MUCH SHELIST		Medicare Application	88.00
9/1/18	MUCH SHELIST		Medicare Application	88.00
10/1/18	MUCH SHELIST		Medicare Application	12.93
11/30/18	ROBBINS, SALOMON & PRATT, LTD		Payroll Tax Appeals	5,000.00
11/20/18	POLSINELLI PC		Collections / Contract Review	1,080.00
12/20/18	POLSINELLI PC		Collections / Contract Review	4,800.00
12/31/18	BANK LEUMI - LEGAL		Loan Restructure	22,032.00
12/31/18	BANK LEUMI - LEGAL		Loan Restructure	90,478.00

			TOTAL LEGAL FEES	149,678.93
				==========

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? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(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?
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 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. $ **333,137**
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