		FOR BHF USE					

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0049502

Facility Name: WINDSOR ESTATES NSG REHAB

Address: 18300 SOUTH LAVERGNE (Number) CNTRY CLUB HILLS (City) 60478 (Zip Code)

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 3/17/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) ELI ATKIN
(Title) MEMBER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	73,200	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	200	TOTALS	200	73,200	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			7,964	7,964	8
9	SNF/PED					9
10	ICF	30,846	3,063	6,175	40,084	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,846	3,063	14,139	48,048	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.64%

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 7,964

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	699,745	95,611	34,956	830,312		830,312		830,312			1
2	Food Purchase		404,706		404,706		404,706	(1,750)	402,956			2
3	Housekeeping	444,509	84,427		528,936		528,936		528,936			3
4	Laundry	175,921	66,483	7,303	249,707		249,707		249,707			4
5	Heat and Other Utilities			275,392	275,392		275,392		275,392			5
6	Maintenance	97,020	53,281	149,885	300,186		300,186		300,186			6
7	Other (specify):*			44,777	44,777		44,777		44,777			7
8	**TOTAL General Services**	1,417,195	704,508	512,313	2,634,016		2,634,016	(1,750)	2,632,266			8
	B. Health Care and Programs											
9	Medical Director			38,500	38,500		38,500		38,500			9
10	Nursing and Medical Records	5,443,744	573,020	37,894	6,054,658		6,054,658		6,054,658			10
10a	Therapy	1,097,982	5,428	8,361	1,111,771		1,111,771		1,111,771			10a
11	Activities	166,329	10,037		176,366		176,366		176,366			11
12	Social Services	26,105			26,105		26,105		26,105			12
13	CNA Training			18,700	18,700		18,700		18,700			13
14	Program Transportation			5,868	5,868		5,868		5,868			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,734,160	588,485	109,323	7,431,968		7,431,968		7,431,968			16
	C. General Administration											
17	Administrative	181,463		10,000	191,463		191,463	117,071	308,534			17
18	Directors Fees											18
19	Professional Services			575,185	575,185		575,185		575,185			19
20	Dues, Fees, Subscriptions & Promotions			48,129	48,129		48,129	(9,550)	38,579			20
21	Clerical & General Office Expenses	448,810	48,888	523,024	1,020,722		1,020,722	(461,259)	559,463			21
22	Employee Benefits & Payroll Taxes			1,480,675	1,480,675		1,480,675		1,480,675			22
23	Inservice Training & Education			1,914	1,914		1,914		1,914			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,967	14,967		14,967		14,967			25
26	Insurance-Prop.Liab.Malpractice			829,651	829,651		829,651		829,651			26
27	Other (specify):*			292,907	292,907		292,907	(292,907)				27
28	**TOTAL General Administration**	630,273	48,888	3,776,452	4,455,613		4,455,613	(646,645)	3,808,968			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,781,628	1,341,881	4,398,088	14,521,597		14,521,597	(648,395)	13,873,202			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID# WINDSOR ESTATES NSG REHAB **#0049502 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	28,494	
	REPAIRS & MAINTENANCE		864	
	OUTSIDE SERVICES		5,598	
				34,956
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,303	
	CONTRACTED LAUNDRY SERVICES		0	
				7,303
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,455	
	ELECTRICITY		151,517	
	WATER		87,420	
	CABLE TV - LOBBY		0	
				275,392
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		37,814	
	PAINTING & DECORATING		1,962	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,333	
	ELEVATOR MAINTENANCE & REPAIR		19,927	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,680	
	FIRE SERVICE		20,539	
	SECURITY SERVICE		56,630	
				149,885
7	**OTHER**			
	SCAVENGER		44,777	
				44,777
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		38,500	38,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		14,700	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	5,760	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	17,434	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				37,894
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	8,361	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				8,361
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	18,700	18,700

Facility Name & ID# WINDSOR ESTATES NSG REHAB **#0049502 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,868	
				5,868
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	10,000	10,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	131,022	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	444,163	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				575,185
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,450	
	EMPLOYEE WANT ADS	XIX F	2,534	
	CONTRIBUTIONS	VI 20 XIX F	4,100	
	DUES & SUBSCRIPTIONS	XIX F	7,333	
	LICENSES & PERMITS	XIX F	4,804	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	19,423	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	4,485	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				48,129
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		76,476	
	EQUIPMENT REPAIR & MAINTENANCE			
	OUTSIDE CLERICAL SERVICES		376,185	
	PENALTIES / OVERDRAFT CHARGES	VI 18	24,155	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		189	
	TELEPHONE		46,019	
	MESSENGER SERVICE		0	
				523,024

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	698,194	
	UNEMPLOYMENT COMPENSATION	XIX D	114,636	
	WORKERS COMPENSATION INSURANCE	XIX D	282,584	
	HOSPITALIZATION INSURANCE	XIX D	367,077	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,673	
	EMPLOYEE PHYSICAL EXAMS	XIX D	511	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				1,480,675
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		1,914	
				1,914
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		14,967	
				14,967
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		829,651	
				829,651
27	**OTHER**			
	BAD DEBTS	VI 24	292,907	
				292,907

GRAND TOTAL COLUMN 3 OTHER **4,398,088**

Facility Name & ID Number WINDSOR ESTATES NSG REHAB #0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,674	33,674		33,674	812,361	846,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			414,553	414,553		414,553	1,648,563	2,063,116			32
33	Real Estate Taxes							690,802	690,802			33
34	Rent-Facility & Grounds			2,040,000	2,040,000		2,040,000	(2,040,000)				34
35	Rent-Equipment & Vehicles			238,012	238,012		238,012		238,012			35
36	Other (specify):*											36
37	TOTAL Ownership			2,726,239	2,726,239		2,726,239	1,111,726	3,837,965			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		330,686	17,192	347,878		347,878		347,878			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			405,143	405,143		405,143		405,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		330,686	422,335	753,021		753,021		753,021			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,781,628	1,672,567	7,546,662	18,000,857		18,000,857	463,331	18,464,188			45

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,373	30		9
10	Interest and Other Investment Income	(13,635)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,750)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(24,155)	21		18
19	Entertainment		20		19
20	Contributions	(4,100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(292,907)	27		24
25	Fund Raising, Advertising and Promotional	(5,450)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(265,528)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (558,152)		$	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)	1,021,483		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,021,483		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 463,331		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.			$		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	**TOTAL (C): (sum of lines 38-46)**			$		47

WINDSOR ESTATES NSG REHAB

ID# 0049502

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (265,528)	21	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
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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**	(265,528)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,750)	0	0	0	0	0	0	0	0	0	0	(1,750)	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	(1,750)	0	0	0	0	0	0	0	0	0	0	(1,750)	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	117,071	0	0	0	0	0	0	0	0	117,071	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	(9,550)	0	0	0	0	0	0	0	0	0	0	(9,550)	20
21	Clerical & General Office Expenses	(289,683)	0	(171,576)	0	0	0	0	0	0	0	0	(461,259)	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):*	(292,907)	0	0	0	0	0	0	0	0	0	0	(292,907)	27
28	TOTAL General Administration	(592,140)	0	(54,505)	0	0	0	0	0	0	0	0	(646,645)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(593,890)	0	(54,505)	0	0	0	0	0	0	0	0	(648,395)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	49,373	762,988	0	0	0	0	0	0	0	0	0	812,361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,635)	1,662,198	0	0	0	0	0	0	0	0	0	1,648,563	32
33	Real Estate Taxes	0	690,802	0	0	0	0	0	0	0	0	0	690,802	33
34	Rent-Facility & Grounds	0	(2,040,000)	0	0	0	0	0	0	0	0	0	(2,040,000)	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**	35,738	1,075,988	0	0	0	0	0	0	0	0	0	1,111,726	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)**	(558,152)	1,075,988	(54,505)	0	0	0	0	0	0	0	0	463,331	45

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
SEE ATTACHED PAGE 6-SUPP						

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	$ 2,040,000	MCALLISTER PROPERTY , LLC		$	$ (2,040,000)	1
2	V								2
3	V								3
4	V	30	DEPRECIATION				762,988	762,988	4
5	V	32	INTEREST				1,501,389	1,501,389	5
6	V	32	AMORT OF LOAN COSTS				160,809	160,809	6
7	V	33	REAL ESTATE TAXES				690,802	690,802	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,040,000			$ 3,115,988	$ * 1,075,988	14

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 376,185	INNOVATIVE MANAGEMENT COMPANY		$	$ (376,185)	15
16	V	17	MANAGEMENT FEES	10,000				(10,000)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATION-ELI ATKIN				20,541	20,541	19
20	V	17	ADMINISTRATION-JOEL ATKIN				10,266	10,266	20
21	V	21	CLERICAL-TZVI ATKIN				26,226	26,226	21
22	V	21	CLERICAL-SHULAMIT ATKIN				929	929	22
23	V	17	ADMINISTRATION-EMANUEL ATKIN				8,485	8,485	23
24	V	17	ADMINISTRATION-CEO				41,083	41,083	24
25	V	17	ADMINISTRATION-CFO				30,702	30,702	25
26	V	17	ADMINISTRATION CONTROLLER				15,994	15,994	26
27	V	17	ADMINISTRATION						27
28	V	21	CLERICAL				89,685	89,685	28
29	V	21	CLERICAL				87,769	87,769	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			$ 386,185			$ 331,680	$ * (54,505)	39

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	JYA ENTERPRISES LLC	42.5	OAKRIDGE HEALTHCARE CENTER ,LLC	HILLSIDE IL.	MCALLISTER			1
2	DONNA ATKIN	42.5			PROPERTY , LLC	TINLEY PARK IL	REAL ESTATE	2
3	HELEN LACEK	5.0	ABINGTON OF GLENVIEW NURSING AND	GLENVIEW , IL				3
4	LORRAINE S. WEINER REVOCABLE T	0.23	REHAB		OAKRIDGE			4
5	NEAL COHEN REVOCABLE TRUST	0.5			PROPERTY , LLC	HILLSIDE	REAL ESTATE	5
6	MICHAEL HERZOG REVOCABLE TRU	0.125						6
7	CHARLES SERLIN	0.75			ABINGTON OF			7
8	HOWARD STILLMAN	0.5			GLENVIEW ,PROP	GLENVIEW	REAL ESTATE	8
9	STEVE GRAPSAS	0.5						9
10	RONALD STILLMAN	0.5			INNOVATIVE MGT	MORTON GROVE	BOOK / MANAGE	10
11	SHARON FELD	0.25						11
12	STEVEN COVICI	0.375						12
13	Z HEALTHCARE	5.0						13
14	ROBERT ETTNER C/O MICHAEL BAU	1.0						14
15	EDWARD WEINER TRUST	0.27						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		PURCHASING		SEE ATTACHED	8.22	21.04	SALARY	$ 26,226	21-7	1
2											2
3	ELISHA ATKIN		ADMINISTRATIVE			8.22	21.04	SALARY	20,541	17-7	3
4											4
5	SHULAMIT ATKIN		ACCOUNTS RECEIVABLE			12.6	33.33	SALARY	929	21-7	5
6											6
7	JOEL ATKIN		ADMINISTRATIVE			8.22	21.04	SALARY	10,266	17-7	7
8											8
9	EMANUEL ETKIN		ADMINISTRATIVE			8.22	21.04.	SALARY	8,485	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 66,447		13

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

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 COMPANY
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	CENSUS DAYS	235,210	6	$ 100,556	$ 100,556	48,048	$ 20,541	1
2	17	ADMINISTRATION-JOEL ATKI	CENSUS DAYS	235,210	6	50,257	50,257	48,048	10,266	2
3	21	CLERICAL-TZVI ATKIN	CENSUS DAYS	235,210	6	128,387	128,387	48,048	26,226	3
4	21	CLERICAL-SHULAMIT ATKIN	CENSUS DAYS	235,210	6	4,550	4,550	48,048	929	4
5	17	ADMINISTRATION-EMANUEL	CENSUS DAYS	235,210	6	41,539	41,539	48,048	8,485	5
6	17	ADMINISTRATION-CEO	CENSUS DAYS	235,210	6	201,112	201,112	48,048	41,083	6
7	17	ADMINISTRATION-CFO	CENSUS DAYS	235,210	6	150,297	150,297	48,048	30,702	7
8	17	ADMINISTRATION CONTROLI	CENSUS DAYS	235,210	6	78,297	78,297	48,048	15,994	8
9	17	ADMINISTRATION	CENSUS DAYS	235,210	6	32,480	32,480		0	9
10	21	CLERICAL	CENSUS DAYS	235,210	6	439,036	439,036	48,048	89,685	10
11	21	CLERICAL	CENSUS DAYS	235,210	6	87,769	87,769	48,048	87,769	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					$ 1,314,280	$ 1,314,280		$ 331,680	25

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	BANK LEUMI		X	MORTGAGE		06/26/18	$ 27,120,000	$ 26,530,460	06/26/21	0.0625	$ 1,092,929	1
2	LOAN COSTS		X	W/O OVER LIFE OF LOAN			482,426	80,404			160,809	2
3	BANK LEUMI		X	REPAIR AND MAINT FUNDING		06/26/18	630,000	616,200	06/26/21	0.0625	25,654	3
4	ABILITY INSURANCE	X		2ND MORTGAGE		3/31/14	5,625,000	5,625,000			382,806	4
5												5
	Working Capital											
6												6
7	GEMINO HC FINANCE		X	WORKING CAPITAL	REVOLV	6/26/18		620,782	6/26/19	PRIME +	225,553	7
8	VARIOUS MEMBERS	X		INTEREST ON CAPITAL							189,000	8
9	TOTAL Facility Related						$ 33,857,426	$ 33,472,846			$ 2,076,751	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 33,857,426	$ 33,472,846			$ 2,076,751	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 706,210	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.)		$ 467,022	2
3. Under or (over) accrual (line 2 minus line 1).		$ (239,188)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 929,990	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.		$ 690,802	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	532,291	8
	2016	346,979	9
	2017	404,093	10
	2018	258,446	11
	2019	266,213	12

LINE 2
2017-$208,576
2018-$258,446

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDSOR ESTATES NSG REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049502

CONTACT PERSON REGARDING THIS REPORT 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-33-403-004-0000	NURSING HOME	$ 76,197.84	$ 76,197.84
2.	28-33-403-005-0000	NURSING HOME	$ 91,318.01	$ 91,318.01
3.	28-33-403-044-0000	NURSING HOME	$ 98,696.78	$ 98,696.78
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 266,212.63	$ 266,212.63

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2			2016	371,149	2
3	TOTALS			$ 371,149	3

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$	$ 2,262,769	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASPHALT PAVING			2016	349,559	11,652	15	23,304	11,652	101,955	9
10	CONCRETE PAVING			2016	161,155	5,372	15	10,744	5,372	47,005	10
11	LANDSCAPING			2016	458,622	15,287	15	30,575	15,288	133,766	11
12	LIGHTING SITE			2016	108,095	3,603	15	7,206	3,603	31,527	12
13	MONUMENT SIGN			2016	20,549	685	15	1,370	685	5,994	13
14	SITE SIGNAGE			2016	19,109	637	15	1,274	637	5,573	14
15	STORM WATER SYSTEM			2016	130,325	4,344	15	8,688	4,344	38,010	15
16	LANDSCAPING			2016	24,325	811	15	1,622	811	6,894	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 21,440,078	$ 559,528		$ 601,920	$ 42,392	$ 2,633,493	70

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 404,390	$ 29,348	$ 40,439	$ 11,091	10	$ 172,397	71
72	Current Year Purchases	4,326	4,326	216	(4,110)	10	216	72
73	Fully Depreciated Assets	200,942					200,942	73
74	RELATED PARTY		203,460	203,460				74
75	TOTALS	$ 609,658	$ 237,134	$ 244,115	$ 6,981		$ 373,555	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	$	$	$	10	$ 8,500	76
77										77
78										78
79										79
80	TOTALS			$ 8,500	$	$	$		$ 8,500	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)	$ 22,429,385	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 796,662	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 846,035	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 49,373	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,015,548	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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.		$
13.		$
14.		$

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: $ 238,012 Description: SEE ATTACHED SCHEDULE
(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			N/A		19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- 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			18,700	18,700
8	CNA Competency Tests				
9	TOTALS	$	$	$ 18,700	$ 18,700
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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			17,192			17,192	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				306,143		306,143	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					24,543		0 24,543	13
14	TOTAL			$		$ 17,192	$ 330,686		$ 347,878	14

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

STATE OF ILLINOIS

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,100,762	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 909,267)	1,889,786		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,059		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,083,615		8
9	Other(specify): Insurance Escrow Deposits	200,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,278,222	$	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	618,158		16
17	Accumulated Depreciation (book methods)	(600,770)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 21,905	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,300,127	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,144,101	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	620,782		29
30	Accrued Salaries Payable	347,869		30
31	Accrued Taxes Payable (excluding real estate taxes)	120,271		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE FR AFFLIATES	4,540,269		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,773,292	$	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	NOTE PAYABLE - PPP	1,963,800		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,963,800	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,737,092	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,436,965)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,300,127	$	48

***(See instructions.)**

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,373,623)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	693,313	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,680,310)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,878,621	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	479,240	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(114,516)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,243,345	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)**	$ (3,436,965)	24 *

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 14,094,288	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,094,288	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	502,550	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 502,550	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	19	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)**	$ 19	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,635	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,635	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS P[AYMENT	4,488,415	28
28a	OTHER EXPENSE ADJUSTMENTS	780,741	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,269,156	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,879,648	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,634,016	31
32	Health Care	7,431,968	32
33	General Administration	4,455,613	33
	B. Capital Expense		
34	Ownership	2,726,239	34
	C. Ancillary Expense		
35	Special Cost Centers	347,878	35
36	Provider Participation Fee	405,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,000,857	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,878,791	41
42	**Income Taxes**	(170)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,878,621	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,504,213	44
45	Private Pay - Net Inpatient Revenue	793,394	45
46	Medicare - Net Inpatient Revenue	5,022,224	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	1,774,457	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,094,288	49

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

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

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

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	2,245	2,384	$ 127,415	$ 53.45	1
2	Assistant Director of Nursing	1,834	1,949	100,378	51.50	2
3	Registered Nurses	20,793	22,124	801,273	36.22	3
4	Licensed Practical Nurses	56,487	60,475	1,894,438	31.33	4
5	CNAs & Orderlies	116,089	124,053	2,116,190	17.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	21,253	23,725	1,097,982	46.28	8
9	Activity Director	1,026	1,261	22,449	17.80	9
10	Activity Assistants	12,147	13,065	143,880	11.01	10
11	Social Service Workers	1,970	2,091	26,105	12.48	11
12	Dietician					12
13	Food Service Supervisor	1,786	1,864	45,975	24.66	13
14	Head Cook	6,075	6,415	87,386	13.62	14
15	Cook Helpers/Assistants	41,989	44,683	566,384	12.68	15
16	Dishwashers					16
17	Maintenance Workers	8,654	9,065	97,020	10.70	17
18	Housekeepers	31,935	34,595	444,509	12.85	18
19	Laundry	13,767	14,569	175,921	12.08	19
20	Administrator	2,002	2,131	146,409	68.70	20
21	Assistant Administrator	1,138	1,229	35,054	28.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,901	19,431	448,810	23.10	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	1,525	1,600	37,778	23.61	31
32	Other Health C: Care Plan Coord	12,181	13,080	346,512	26.49	32
33	Other(specify) Admitting	678	876	19,760	22.56	33
34	TOTAL (lines 1 - 33)	373,475	400,665	$ 8,781,628 *	$ 21.92	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	$ 28,494	1-3	35
36	Medical Director	O	38,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	5,760	10-3	38
39	Pharmacist Consultant	H	17,434	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		8,361	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)		$ 98,549		49

C. CONTRACT NURSES

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

Facility Name & ID Number WINDSOR ESTATES NSG REHAB # 0049502 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
YOSEF TSADIOK	ADMINISTRATOR	0	$ 146,409
ALI BIACHI	ASST ADMIN	0	35,054
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 181,463

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 10,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 10,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 575,185
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 575,185

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 282,584
Unemployment Compensation Insurance	114,636
FICA Taxes	698,194
Employee Health Insurance	367,077
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	17,673
EMPLOYEE PHYSICAL EXAMS	511
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,480,675

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,534
Health Care Worker Background Check	4,485
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	4,100
MARKETING/ADV/PROMO	24,873
LICENSES/DUES/SUBSCRIPTIONS	12,137
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(4,100)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,450)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,579

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

WINDSOR ESTATES NSG REHAB
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
12/12/2019	ADR SYSTEMS	LEGAL SERVICES	1,558.00
6/22/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	484.49
6/22/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	327.43
6/22/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	4,683.19
9/3/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	6,155.00
9/4/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	25,000.00
10/29/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	25,000.00
11/24/2020	AMERICAN EMPIRE SURPLUS LINES INSURANCE	LEGAL SERVICES	20,316.81
1/9/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	6,180.00
4/20/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	4,440.45
3/18/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	2,862.00
2/10/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	3,044.00
3/16/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	5,379.00
4/15/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	5,552.00
4/20/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	4,499.00
1/13/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	3,166.50
5/22/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	2,920.08
5/22/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	2,503.50
5/22/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	248.00
7/23/2020	CLAUSEN MILLER P.C.	LEGAL SERVICES	1,232.00
5/18/2020	COHEN SALK & HUVARD	LEGAL SERVICES	112.50
9/9/2019	COHEN SALK & HUVARD	LEGAL SERVICES	2,730.00
1/9/2020	COHEN SALK & HUVARD	LEGAL SERVICES	3,885.00
7/10/2019	COHEN SALK & HUVARD	LEGAL SERVICES	1,225.00
2/11/2020	COHEN SALK & HUVARD	LEGAL SERVICES	750.00
10/9/2019	COHEN SALK & HUVARD	LEGAL SERVICES	385.00
7/13/2020	COHEN SALK & HUVARD	LEGAL SERVICES	300.00
12/6/2019	COHEN SALK & HUVARD	LEGAL SERVICES	5,208.60
3/9/2020	COHEN SALK & HUVARD	LEGAL SERVICES	750.00
5/4/2020	COHEN SALK & HUVARD	LEGAL SERVICES	1,387.50
5/31/2020	HIPP LAW OFFICE	LEGAL SERVICES	331.73
8/31/2020	HIPP LAW OFFICE	LEGAL SERVICES	180.00
9/30/2020	HIPP LAW OFFICE	LEGAL SERVICES	60.00
12/31/2020	HIPP LAW OFFICE	LEGAL SERVICES	1,332.52
12/4/2019	KLEIN PAULL HOLLEB & JACOBS	LEGAL SERVICES	123.75
12/1/2019	MUCH SHELIST	LEGAL SERVICES	267.00
2/1/2020	MUCH SHELIST	LEGAL SERVICES	270.00
3/1/2020	MUCH SHELIST	LEGAL SERVICES	270.00
1/13/2020	POLSINELLI P.C.	LEGAL SERVICES	372.08
1/13/2020	POLSINELLI P.C.	LEGAL SERVICES	6,809.50
12/18/2019	POLSINELLI P.C.	LEGAL SERVICES	2,846.50
12/18/2019	POLSINELLI P.C.	LEGAL SERVICES	2,760.00
3/6/2020	POLSINELLI P.C.	LEGAL SERVICES	3,568.50
4/22/2020	POLSINELLI P.C.	LEGAL SERVICES	14,619.28
4/22/2020	POLSINELLI P.C.	LEGAL SERVICES	451.00
6/14/2020	POLSINELLI P.C.	LEGAL SERVICES	7,803.08
7/14/2020	POLSINELLI P.C.	LEGAL SERVICES	1,834.50
8/13/2020	POLSINELLI P.C.	LEGAL SERVICES	6,911.00
10/16/2020	POLSINELLI P.C.	LEGAL SERVICES	4,068.00
9/11/2020	POLSINELLI P.C.	LEGAL SERVICES	3,427.08
11/4/2020	POLSINELLI P.C.	LEGAL SERVICES	8,042.00
12/11/2020	POLSINELLI P.C.	LEGAL SERVICES	6,145.00
2/11/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	22,605.12
6/10/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	2,500.00
11/19/2019	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	2,307.50
7/27/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	4,338.00
11/20/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	10,000.00
2/11/2020	STINSON LEONARD STREET LLP	LEGAL SERVICES	146.50
4/10/2020	STINSON LEONARD STREET LLP	LEGAL SERVICES	1,568.00
4/14/2020	STINSON LEONARD STREET LLP	LEGAL SERVICES	1,603.50
4/8/2020	PERFORMANCE FOOD GROUP	LEGAL SETTLEMENT	3,543.18
4/30/2020	GEMINO HC FINANCE	LOC RENEWAL	27,124.55
8/27/2020	CNA INSURANCE	LEGAL SETTLEMENT	57,500.00
	TOTAL		**348,013.92**

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? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **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? **NO**
If YES, give effective date of lease.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **405,143**
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 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.