

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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

<p>I. IDPH Facility ID Number: <u>0031351</u></p> <p>Facility Name: <u>WINDSOR NURSING & REHAB CENTER</u></p> <p>Address: <u>10426 S. ROBERTS ROAD</u> <u>PALOS HILLS</u> <u>60465</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 598-3460</u> Fax # <u>(708) 598-0520</u></p> <p>IDPA ID Number: <u>36-3468459</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:15%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>BRUCE LEDERMAN</u></td> </tr> <tr> <td></td> <td>(Title) <u>VICE PRESIDENT</u></td> </tr> <tr> <td></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>BOB KAGDA/PARTNER</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>BRUCE LEDERMAN</u>		(Title) <u>VICE PRESIDENT</u>		(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	Paid Preparer	(Print Name and Title) <u>BOB KAGDA/PARTNER</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u>
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DPA 3745 (N-4-99)

IL478-2471

[Print Preview](#)

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER

0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	135	Skilled (SNF)	135	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,031	1,265	2,939	14,235	8
9	SNF/PED					9
10	ICF	32,171	13,869		46,040	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,202	15,134	2,939	60,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 81.13%)

D. How many bed-hold days during this year were paid by Public Aid?

151 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 10/01/86

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/01/86 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 24 and days of care provided 1621

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number WINDSOR NURSING & REHAB CEN] # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	232,678	17,247	11,181	261,106		261,106	0	261,106		1
2	Food Purchase		164,980		164,980	(4,831)	160,149	0	160,149		2
3	Housekeeping	233,949	45,043	0	278,992		278,992	0	278,992		3
4	Laundry	61,674	15,551	4,179	81,404		81,404	0	81,404		4
5	Heat and Other Utilities			97,389	97,389		97,389	0	97,389		5
6	Maintenance	44,864	9,495	55,815	110,174		110,174	3,595	113,769		6
7	Other (specify):*			8,978	8,978		8,978	0	8,978		7
8	TOTAL General Services	573,165	252,316	177,542	1,003,023	(4,831)	998,192	3,595	1,001,787		8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500		16,500	0	16,500		9
10	Nursing and Medical Records	1,923,653	155,447	8,233	2,087,333		2,087,333	0	2,087,333		10
10a	Therapy	168,206	841	121	169,168		169,168	0	169,168		10a
11	Activities	122,962	5,196	1,529	129,687		129,687	0	129,687		11
12	Social Services	0		5,200	5,200		5,200	0	5,200		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	2,214,821	161,484	31,583	2,407,888		2,407,888		2,407,888		16
	C. General Administration										
17	Administrative	189,455		0	189,455		189,455	0	189,455		17
18	Directors Fees			0				0			18
19	Professional Services			61,859	61,859		61,859	0	61,859		19
20	Dues, Fees, Subscriptions & Promotions			46,890	46,890		46,890	(19,846)	27,044		20
21	Clerical & General Office Expense	156,712	28,729	31,270	216,711		216,711	0	216,711		21
22	Employee Benefits & Payroll Taxes			444,643	444,643	4,831	449,474	0	449,474		22
23	Inservice Training & Education			0				0			23
24	Travel and Seminar			2,490	2,490		2,490	0	2,490		24
25	Other Admin. Staff Transportation			2,394	2,394		2,394	0	2,394		25
26	Insurance-Prop.Liab.Malpractice			79,560	79,560		79,560	0	79,560		26
27	Other (specify):*			0				0			27
28	TOTAL General Administration	346,167	28,729	669,106	1,044,002	4,831	1,048,833	(19,846)	1,028,987		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,134,153	442,529	878,231	4,454,913		4,454,913	(16,251)	4,438,662		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.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			56,030	56,030		56,030	(8,288)	47,742			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			405	405		405	6,635	7,040			32
33	Real Estate Taxes			297,399	297,399		297,399	14,703	312,102			33
34	Rent-Facility & Grounds			863,213	863,213		863,213	0	863,213			34
35	Rent-Equipment & Vehicles			18,412	18,412		18,412	0	18,412			35
36	Other (specify):* OFFICE			40,698	40,698		40,698	(40,698)				36
37	TOTAL Ownership			1,276,157	1,276,157		1,276,157	(27,648)	1,248,509			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		88,998	7,913	96,911		96,911	0	96,911			39
40	Barber and Beauty Shops			413	413		413	0	413			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			111,448	111,448		111,448	0	111,448			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		88,998	119,774	208,772		208,772		208,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,134,153	531,527	2,274,162	5,939,842	0	5,939,842	(43,899)	5,895,943			45

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

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **WINDSOR NURSING & REHAB CENTER**

0031351

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(12,974)	30		9
10	Interest and Other Investment Income	(405)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(14,370)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(5,276)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>DEFERRED MAINT XIX-H</u>	3,595	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,630)		\$	30

OHF USE ONLY						
48		49		50		51
						52

Print Previe

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,269)	SCHED	34
35	Other- Attach Schedule	0	ATTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (14,269)		36
37	TOTAL ADJUSTMENTS (A) and (B) 	\$ (43,899)		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.

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Detail lines 29 and 35 of Page 5 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
 The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS Page 5A
 Facility Name WINDSOR NURSING & REHAB CENTER
 ID# 0031351
 Report Period Beginning: 01/01/2000
 Ending: 12/31/2000

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.				
1 Day Care	0	0	Line 1	0
2 Other Care for Outpatients	0	0	Line 2	0
3 Governmental Sponsored Special Programs	0	0	Line 3	0
4 Non-Patient Meals	0	2	Line 4	0
5 Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6 Rented Facility Space	0	34	Line 6	3,595
7 Sale of Supplies to Non-Patients	0	10	Line 7	0
8 Laundry for Non-Patients	0	4	Line 8	3,595
9 Non-Straightline Depreciation	(12,974)	30	Line 9	0
10 Interest and Other Investment Income	(405)	32	Line 10	0
11 Discounts, Allowances, Rebates & Refunds	0	2	Line 10a	0
12 Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13 Sales Tax	0	2	Line 12	0
14 Non-Care Related Interest	0	32	Line 13	0
15 Non-Care Related Owner's Transactions	0	0	Line 14	0
16 Personal Expenses (Including Transportation)	0	25	Line 15	0
17 Non-Care Related Fees	(200)	20	Line 16	0
18 Fines and Penalties	0	21	Line 17	0
19 Entertainment	0	20	Line 18	0
20 Contributions	(14,370)	20	Line 19	0
21 Owner or Key-Man Insurance	0	22	Line 20	(19,846)
22 Special Legal Fees & Legal Retainers	0	19	Line 21	0
23 Malpractice Insurance for Individuals	0	26	Line 22	0
24 Bad Debt	0	27	Line 23	0
25 Fund Raising, Advertising and Promotional	(5,276)	20	Line 24	0
26 Income & IL Personal Property Replacement Tax	0	0	Line 25	0
27 Nurse Aide Training for Non-Employees	0	13	Line 26	0
28 Yellow Page Advertising	0	20	Line 27	0
29 Non-Paid Workers	0	0	Line 28	(19,846)
30 Donated Goods	0	0	Line 29	(16,251)
31 Amortization Expense	0	0	Line 30	(12,974)
32 DEF MAINT	3,595	6	Line 31	0
33			Line 32	(405)
34			Line 33	0
35			Line 34	0

Print Other Adjustment

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Line 35	<u>0</u>
Line 36	<u>0</u>
Line 37	<u>(13,379)</u>
Line 38	<u>0</u>
Line 39	<u>0</u>
Line 40	<u>0</u>
Line 41	<u>0</u>
Line 42	<u>0</u>
Line 43	<u>0</u>
Line 44	<u>0</u>
Line 45	<u>(29,630)</u>

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS
 Facility Name & ID Number: WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000
 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Summary A

Print Summary

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	3,595	0	0	0	0	0	0	0	0	0	0	3,595 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	3,595	0	0	0	0	0	0	0	0	0	0	3,595 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	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	(19,846)	0	0	0	0	0	0	0	0	0	0	(19,846) 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 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):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	(19,846)	0	0	0	0	0	0	0	0	0	0	(19,846) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,251)	0	0	0	0	0	0	0	0	0	0	(16,251) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(12,974)	4,686	0	0	0	0	0	0	0	0	0	(8,288) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(405)	7,040	0	0	0	0	0	0	0	0	0	6,635 32
33	Real Estate Taxes	0	14,703	0	0	0	0	0	0	0	0	0	14,703 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	(40,698)	0	0	0	0	0	0	0	0	0	(40,698) 36
37	TOTAL Ownership	(13,379)	(14,269)	0	(27,648) 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)	(29,630)	(14,269)	0	(43,899) 45								

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6

Show Pgs 6E thru 6

Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HAROLD LEDERMAN	0.4581	THE CLAREMONT REHAB & LIVING CENT	BUFFALO GROVE	FREEDOM HOME	BUFFALO GROVE	HOME CARE
BRUCE LEDERMAN	.4926	THE CLAREMONT OF LEE COUNTY	DIXON	WINDSOR HEALT	CHICAGO	REAL ESTATE
ANDREA WEITZBERG	.0493			CARE MNGT		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		Sum_6
1	V	36 BOOKKEEPING OFFICE	\$ 40,698	10418 S. ROBERTS RD.		\$	\$ (40,698)	1 -40698
2	V							2
3	V							3
4	V	30 DEPRECIATION		10418 S. ROBERTS RD.		4,686	4,686	4 4686
5	V	32 INTEREST		10418 S. ROBERTS RD.		7,040	7,040	5 7040
6	V	33 REAL ESTATE TAXES		10418 S. ROBERTS RD.		14,703	14,703	6 14703
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 40,698			\$ 26,429	\$ * (14,269)	14

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6A

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning 01/01/2000 Ending: 12/31/2000

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6A

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER

0031351

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

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

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6D

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

Sum_6D

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

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRUCE LEDERMAN	VICE PRESIDENT	ADMIN	49.26				SALARY	\$ 106,873	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 106,873		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.

Print Preview

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Print Previe

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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					\$	\$			\$	1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	UPAC	X	INSURANCE FINANCING			0			405	6										
7										7										
8	RELATED PARTY	X							7,040	8										
9	TOTAL Facility Related				\$	\$			\$ 7,445	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related				\$	\$			\$	14										
15	TOTALS (line 9+line14)				\$	\$			\$ 7,445	15										

* 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.)

Print Previe

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	309,000	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.)	\$	303,162	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(5,838)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	304,500	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 used previously to calculate a payment rate. 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 <u>1,263</u> For <u>19 94</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(1,263)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	297,399	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<u>279,536</u>	8
	1996	<u>293,473</u>	9
	1997	<u>294,278</u>	10
	1998	<u>305,939</u>	11
	1999	<u>303,162</u>	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.			
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATIO \$	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.

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

D. Does the Operating Entity? (a) Own the Equipment (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	94,210		\$	1
2					2
3	TOTALS	94,210		\$	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8					4,686		4,686			8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENT		1986	2,605	138	30	87	(51)	1,229	9
10	LEASEHOLD IMPROVEMENT		1988	7,660	243	30	255	12	3,177	10
11	LEASEHOLD IMPROVEMENT		1989	17,237	3,957	30	442	(3,515)	1,485	11
12	LEASEHOLD IMPROVEMENT		1989	1,600	51	30	41	(10)	1,338	12
13	LEASEHOLD IMPROVEMENT		1990	3,850	122	30	99	(23)	1,396	13
14	LEASEHOLD IMPROVEMENT		1991	21,282	676	30	546	(130)	5,005	14
15	LEASEHOLD IMPROVEMENT		1992	17,645	560	30	452	(108)	3,842	15
16	LEASEHOLD IMPROVEMENT		1993	13,966	443	31.5	358	(85)	2,864	16
17	LEASEHOLD IMPROVEMENT		1993	1,456	37	39	37		270	17
18	LEASEHOLD IMPROVEMENT		1994	6,777	174	39	174		1,140	18
19	FLOORING		1995	806	21	39	21		120	19
20	CONSTRUCT WALL		1995	641	16	39	16		90	20
21	NEW ROOF		1996	143,257	3,673	39	3,673		16,991	21
22	FLOOR REPAIR, FURNISH & INSTALL TILE		1996	37,055	950	39	950		4,157	22
23	REMODEL BATHROOM		1996	2,600	67	39	67		271	23
24	KITCHEN TILE		1997	2,300	59	39	59		224	24
25	DINING ROOM FIXTURES, PAINT & WALLPAPER		1997	1,090	28	39	28		101	25
26	FIRE ALARM SYSTEM		1998	109,410	2,805	39	2,805		6,656	26
27	HOT WATER BOILER		1998	18,132	465	39	465		949	27
28	FUEL STORAGE TANK		1999	3,558	91	39	91		160	28
29	ELECTRICAL WORK		1999	2,467	63	39	63		92	29
30	INSTALL CERAMIC TILES		1999	825	21	39	21		27	30
31										31
32										32
33										33
34										34
35										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 19,346		\$ 15,436	\$ (3,910)	\$ 51,584	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number: WINDSOR NURSING & REHAB CENTER

0031351

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
			Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12B

Facility Name & ID Number: WINDSOR NURSING & REHAB CENTER

0031351

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
			Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number: WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	4
5									5
6									6
7									7
8									8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3									
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12D

Facility Name & ID Number: WINDSOR NURSING & REHAB CENTER

0031351

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										36
					\$ #VALUE!	\$		\$	\$	\$	

*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.

Print Previe

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 317,248	\$ 31,852	\$ 30,475	\$ (1,377)	7-10 YRS	\$ 180,588	37
38	Current Year Purchases	36,615	9,518	1,831	(7,687)	10 YRS	1,831	38
39	Fully Depreciated Assets	39,097					39,097	39
40								40
41	TOTALS	\$ 392,960	\$ 41,370	\$ 32,306	\$ (9,064)		\$ 221,516	41

D. Vehicle Depreciation (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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 60,716	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 47,742	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (12,974)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 273,100	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

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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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	203		\$ 863,213	30		3
4	Additions						4
5							5
6							6
7	TOTAL	203		\$ 863,213			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 YEARS \$35,000. PER BED*

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 equipme \$ 9,652 Description: SEE SCHEDULE ATTACHED

(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	<u>PATIENT TRANSP</u>	<u>2000 DODGE VAN</u>	\$ <u>389.00</u>	\$ <u>4,668</u>	17
18	<u>ADMINISTRATOR</u>	<u>1999 ACURA</u>	<u>516.00</u>	<u>6,192</u>	18
19	<u>PAYROLL DEDUCTION</u>			<u>(2,100)</u>	19
20					20
21	TOTAL		\$ <u>905.00</u>	\$ <u>8,760</u>	21

10. Effective dates of current rental agreement:

Beginning 01/01/86

Ending 09/30/16

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 09/30/2001 \$ 871,549

13. 09/30/2002 \$ 881,737

14. 09/30/2003 \$ 890,072

* 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.

Print Previe

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

	ALLOCATION OF COSTS (d)			
	1	2	3	4
	Facility		Contract	Total
	Drop-outs	Completed		
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 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	2	3	4				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 135	\$		\$ 135	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,488			3,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		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 prescripts				33,359		33,359	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, RENTALS, OTHER SERVICE Other (specify): SUPPLIES	39-3 39-2					59,929		59,929	13
14	TOTAL			\$		\$ 3,623	\$ 93,288		\$ 96,911	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 nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

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	\$ 0	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,183,079		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	206,320		6
7	Other Prepaid Expenses	74,963		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	21,985		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,486,347	\$	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 Cos	416,219		15
16	Equipment, at Historical Cost	392,960		16
17	Accumulated Depreciation (book methods)	(382,008)		17
18	Deferred Charges	183,404		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)	\$ 610,575	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,096,922	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 399,054	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,425		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,787		31
32	Accrued Real Estate Taxes(Sch.IX-B)	304,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 851,766	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	803,306		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 803,306	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,655,072	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 441,850	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,096,922	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 440,814	1
2	Restatements (describe):		2
3	REPLACEMENT TAX	(4,604)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 436,210	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	155,229	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	(149,589)	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)	\$ 5,640	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)	\$ 441,850	24 *

* This must agree with page 17, line 47.

Print Previe

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER # 0031351 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,024,077	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,024,077	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,795	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 65,795	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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***	5,199	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,199	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,095,071	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,003,023	31
32	Health Care	2,407,888	32
33	General Administration	1,044,002	33
B. Capital Expense			
34	Ownership	1,276,157	34
C. Ancillary Expense			
35	Special Cost Centers	97,324	35
36	Provider Participation Fee	111,448	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,939,842	40
41	Income before Income Taxes (line 30 minus line 40)**	155,229	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 155,229	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

Print Preview

Facility Name & ID Number WINDSOR NURSING & REHAB CENTER

0031351

Report Period Beginning 01/01/2000

Ending:

12/31/2000

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,812	2,080	\$ 59,866	\$ 28.78	1
2	Assistant Director of Nursing	1,680	1,680	37,547	22.35	2
3	Registered Nurses	20,808	23,983	486,049	20.27	3
4	Licensed Practical Nurses	15,255	16,531	293,803	17.77	4
5	Nurse Aides & Orderlies	74,814	80,460	832,805	10.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,098	4,402	89,822	20.40	7
8	Rehab/Therapy Aides	7,652	8,501	78,384	9.22	8
9	Activity Director	1,784	2,080	30,914	14.86	9
10	Activity Assistants	11,696	13,019	92,048	7.07	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,995	2,080	38,082	18.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,236	24,787	194,596	7.85	15
16	Dishwashers					16
17	Maintenance Workers	2,119	2,591	44,864	17.32	17
18	Housekeepers	30,891	33,049	233,949	7.08	18
19	Laundry	7,209	7,862	61,674	7.84	19
20	Administrator	2,600	2,800	148,212	52.93	20
21	Assistant Administrator	1,856	2,080	41,243	19.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,685	12,905	156,712	12.14	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	5,423	6,240	126,844	20.33	31
32	Other Health Care(specify)					32
33	Other(specify Psycho-Social)	8,626	9,170	86,739	9.46	33
34	TOTAL (lines 1 - 33)	235,239	256,300	\$ 3,134,153 *	\$ 12.23	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M \$ 9,336	1-3	35
36	Medical Director	O 16,500	9-3	36
37	Medical Records Consultant	N 4,032	10-3	37
38	Nurse Consultant	T 0	10-3	38
39	Pharmacist Consultant	H 1,800	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	0	10a-3	42
43	Speech Therapy Consultant	F 0	10a-3	43
44	Activity Consultant	E 243	11-3	44
45	Social Service Consultant	E 5,200	12-3	45
46	Other(specify)			46
47	DENTAL	1,200	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 38,311		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10-3	50
51	Licensed Practical Nurses		10-3	51
52	Nurse Aides	15 266	10-3	52
53	TOTAL (lines 50 - 52)	15 \$ 266		53

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY1997	6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005
1	PAINT/DECORATI	1996	\$ 3,515	3 YR	\$ 1,172	\$ 1,172	\$ 586	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATI	1997	12,541	3 YR	2,090	4,180	4,180	2,091					
3	PAINT/DECORATI	1998	4,513	3 YR		752	1,504	1,504	753				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 20,569		\$ 3,262	\$ 6,104	\$ 6,270	\$ 3,595	\$ 753	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount: IL COUNCIL LONG TERM CARE \$8,374
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? 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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. 56,024 Line 10
- (7) Have all costs reported on this form been determined using accounting procedure 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 of Public Aid during this cost report period. 111,448
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 of Public Aid, 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 _____ 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 benefit 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 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER			
LINE	SCHED REF	TOTAL	LINE	SCHED REF	TOTAL
1			10		
DIETARY			NURSING		
DIETITIAN CONSULTANT	XVIII B35	9336	CONTRACT NURSING	XVIII C53	266
REPAIRS & MAINTENANCE		1845	LABORATORY & XRAY EXPENSE		0
		0	11181	PURCHASED SERVICES	935
3					
HOUSEKEEPING			PSYCHO-SOCIAL CONSULTANT	XVIII B47	0
		0	RESTORATIVE NURSING CONSULTANT	XVIII B38	0
		0	0	MEDICAL RECORDS CONSULTANT	XVIII B37
4					
LAUNDRY			PHARMACY CONSULTANT	XVIII B39	1800
EQUIPMENT REPAIRS & MAINTENANCE		4179	UTILIZATION REVIEW FEES	XVIII B	0
		0	4179	PHYSICIANS	XVIII B
5					
HEAT & OTHER UTILITIES			PSYCHIATRIC	XVIII B	0
GAS HEAT		29222	RN CONSULTANT	XVIII B38	0
ELECTRICITY		51944	DENTAL		1200
WATER		16223			0
CABLE TV - LOBBY		0	10a		8233
		0	97389	THERAPY	
6					
MAINTENANCE			PHYSICAL THERAPY SERVICES		0
GROUND MAINTENANCE		10201	SPEECH THERAPY SERVICES		121
PAINTING & DECORATING		1064	OCCUPATIONAL THERAPY SERVICES		0
BUILDING REPAIRS		4808	REHABILITATION CONSULTANT	XVIII B	0
MAINTENANCE TRAVEL		0	PHYSICAL THERAPY CONSULTANT	XVIII B40	0
EQUIPMENT MAINTENANCE & REPAIR		29731	OCCUPATIONAL THERAPY CONSULTANT	XVIII B41	0
ELEVATOR MAINTENANCE & REPAIR		0	SPEECH THERAPY CONSULTANT	XVIII B43	0
OUTSIDE LABOR		0	RESPIRATORY CONSULTANT	XVIII B42	0
EXTERMINATING SERVICE		2150	11		121
FIRE SERVICE		7861	ACTIVITIES		
		0	CABLE TV - PATIENT ROOMS		1286
		0	ACTIVITY REHAB CONSULTANT	XVIII B44	243
		0			0
		0	12		1529
		55815	SOCIAL SERVICES		
7			SOCIAL REHABILITATION SERVICES		0
OTHER			SOCIAL REHABILITATION CONSULTANT	XVIII B45	0
SCAVENGER		8687	SOCIAL WORKER	XVIII B45	5200
SECURITY SERVICE		291			0
		8978			5200
9			13		
MEDICAL DIRECTOR			NURSE AIDE TRAINING		
MEDICAL DIRECTOR FEES	XVIII B36	16500	NURSE AIDE TRAINING COSTS	XIII	0
		16500			0

V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER			
LINE	SCHED REF	TOTAL	LINE	SCHED REF	TOTAL
14			22		
PROGRAM TRANSPORTATION			EMPLOYEE BENEFITS & PAYROLL TAXES		
PATIENT TRANSPORTATION		0	FICA TAXES	XIX D	235536
			UNEMPLOYMENT COMPENSATION	XIX D	22502
17			WORKERS COMPENSATION INSURANCE	XIX D	80192
ADMINISTRATIVE			HOSPITALIZATION INSURANCE	XIX D	77902
MANAGEMENT FEES	XIX B	0	EMPLOYEE BENEFITS - OTHER	XIX D	6110
18			EMPLOYEE PHYSICAL EXAMS	XIX D	345
DIRECTORS FEES		0	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
19			PENSION/PROFIT SHARING CONTRIBUTIONS	XIX D	22056
PROFESSIONAL SERVICES			CHICAGO HEAD TAX	XIX D	0
DATA PROCESSING	XIX C	14309	23		
ADMINISTRATIVE CONSULTANTS	XIX C	0	INSERVICE TRAINING & EDUCATION		
PROFESSIONAL FEES	XIX C	47550	EDUCATION & SEMINARS		0
ACCOUNT COLLECTION FEES		0			444643
20			24		
FEES,SUBSCRIPTIONS,PROMOTIONS			TRAVEL & SEMINARS		0
ENTERTAINMENT	VI 19 XIX F	0	EDUCATION & SEMINARS	XIX G	2490
ADV & PROMO/MARKETING	VI 25 XIX F	5276	TRAVEL	XIX G	0
EMPLOYEE WANT ADS	XIX F	9040			0
CONTRIBUTIONS	VI 20 XIX F	14120	25		
DUES & SUBSCRIPTIONS	XIX F	16531	ADMIN. STAFF TRANSPORTATION		
LICENSES & PERMITS	XIX F	659	TRANSPORTATION - STAFF		2394
PUBLIC RELATIONS-PATIENT RELATIONS	XIX F	0			2394
ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	26		
TRUST FEES/FRANCHISE TAX	VI 17 XIX F	200	INSURANCE - PROP. LIAB & MALPRACTICE		
CONTRIBUTIONS - POLITICAL	VI 20 XIX F	250	GENERAL INSURANCE		79560
H/CARE WORKER BACKGROUND CHECKS	XIX F	814			79560
21			27		
CLERICAL & GENERAL OFFICE EXPENSES			OTHER		
BANK CHARGES		88	BAD DEBTS	VI 24	0
EQUIPMENT REPAIR & MAINTENANCE		13563			0
OUTSIDE CLERICAL SERVICES		0			0
PENALTIES	VI 18	0			
HOME OFFICE EXPENSE		0			
THEFT & DAMAGE LOSS		0			
TELEPHONE		17619			
MESSENGER SERVICE		0			
			GRAND TOTAL COLUMN 3 OTHER		878231