



Facility Name & ID Number Windsor Park Manor

# 0034652 Report Period Beginning: 02/01/17 Ending: 01/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,576	13,824	7,798	24,198	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,576	13,824	7,798	24,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.87%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 36 and days of care provided 5,958

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/31/18 Fiscal Year: 01/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor # 0034652 Report Period Beginning: 02/01/17 Ending: 01/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	312,649	45,035	126,112	483,796		483,796		483,796		1
2	Food Purchase		308,107		308,107		308,107	(5,195)	302,912		2
3	Housekeeping	111,791	12,667	900	125,358		125,358		125,358		3
4	Laundry	18,029	9,475		27,504		27,504		27,504		4
5	Heat and Other Utilities			74,919	74,919		74,919		74,919		5
6	Maintenance	45,728	4,450	122,635	172,813		172,813	(365)	172,448		6
7	Other (specify):* See Supplemental										7
8	<b>TOTAL General Services</b>	488,197	379,734	324,566	1,192,497		1,192,497	(5,560)	1,186,937		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,652,610	103,243	34,860	2,790,713		2,790,713		2,790,713		10
10a	Therapy										10a
11	Activities	112,897		20,872	133,769		133,769		133,769		11
12	Social Services	152,313	11	22,100	174,424		174,424		174,424		12
13	CNA Training										13
14	Program Transportation	17,193			17,193		17,193	(2,233)	14,960		14
15	Other (specify):* See Supplemental										15
16	<b>TOTAL Health Care and Programs</b>	2,935,013	103,254	113,832	3,152,099		3,152,099	(2,233)	3,149,866		16
	<b>C. General Administration</b>										
17	Administrative	94,466			94,466		94,466		94,466		17
18	Directors Fees										18
19	Professional Services			672,726	672,726		672,726	(73,824)	598,902		19
20	Dues, Fees, Subscriptions & Promotions			35,446	35,446		35,446		35,446		20
21	Clerical & General Office Expenses	235,222	12,432	97,329	344,983		344,983	(90,052)	254,931		21
22	Employee Benefits & Payroll Taxes			940,951	940,951		940,951		940,951		22
23	Inservice Training & Education			2,130	2,130		2,130		2,130		23
24	Travel and Seminar			934	934		934	(23)	911		24
25	Other Admin. Staff Transportation			4,128	4,128		4,128	(325)	3,803		25
26	Insurance-Prop.Liab.Malpractice			70,821	70,821		70,821		70,821		26
27	Other (specify):* See Supplemental										27
28	<b>TOTAL General Administration</b>	329,688	12,432	1,824,465	2,166,585		2,166,585	(164,224)	2,002,361		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,752,898	495,420	2,262,863	6,511,181		6,511,181	(172,017)	6,339,164		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number

Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			526,066	526,066		526,066		526,066		30
31	Amortization of Pre-Op. & Org.			1,440	1,440		1,440	(1,440)			31
32	Interest			66,386	66,386		66,386	(66,386)			32
33	Real Estate Taxes			50,785	50,785		50,785		50,785		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			9,117	9,117		9,117		9,117		35
36	Other (specify):* See Supplemental										36
37	<b>TOTAL Ownership</b>			653,794	653,794		653,794	(67,826)	585,968		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		333,150	985,046	1,318,196		1,318,196		1,318,196		39
40	Barber and Beauty Shops			15,301	15,301		15,301		15,301		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			69,123	69,123		69,123		69,123		42
43	Other (specify):* See Supplemental	10,015	235	19,049	29,299		29,299	(29,299)			43
44	<b>TOTAL Special Cost Centers</b>	10,015	333,385	1,088,519	1,431,919		1,431,919	(29,299)	1,402,620		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,762,913	828,805	4,005,176	8,596,894		8,596,894	(269,142)	8,327,752		45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/17 - 01/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
<b>Line 36 - Other Capital Costs</b>				
				-
				-
				-
				-
				-
				-
				-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 43 - Other Special Cost Centers</b>				
Fundraising	10,015		2,728	12,743
Marketing		235	16,321	16,556
				-
				-
				-
				-
<b>Sub-Total</b>	<u>10,015</u>	<u>235</u>	<u>19,049</u>	<u>29,299</u>

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,195)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,989)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(66,386)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,404)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(43,344)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (195,318)</b>		<b>\$</b>	<b>30</b>

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)	(73,824)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (73,824)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (269,142)</b>		<b>37</b>

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Windsor Park Manor

ID# 0034652

Report Period Beginning: 02/01/17

Ending: 01/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Revenue	\$ (2,233)	14	1
2	Maintenance Revenue	(365)	06	2
3	Other Operating Revenue	(582)	21	3
4	Sales Tax	(9,077)	21	4
5	Training	(23)	24	5
6	Travel	(325)	25	6
7	Amortization	(1,440)	31	7
8	Fundraising	(12,743)	43	8
9	Marketing	(16,556)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(43,344)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Windsor Park Manor

# 0034652 Report Period Beginning:

02/01/17

Ending:

01/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,195)	0	0	0	0	0	0	0	0	0	0	(5,195)	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	(365)	0	0	0	0	0	0	0	0	0	0	(365)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,560)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,560)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,233)	0	0	0	0	0	0	0	0	0	0	(2,233)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,233)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,233)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(73,824)	0	0	0	0	0	0	0	0	0	(73,824)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(90,052)	0	0	0	0	0	0	0	0	0	0	(90,052)	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	(23)	0	0	0	0	0	0	0	0	0	0	(23)	24
25	Other Admin. Staff Transportation	(325)	0	0	0	0	0	0	0	0	0	0	(325)	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	<b>TOTAL General Administration</b>	<b>(90,400)</b>	<b>(73,824)</b>	<b>0</b>	<b>(164,224)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(98,193)</b>	<b>(73,824)</b>	<b>0</b>	<b>(172,017)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(1,440)	0	0	0	0	0	0	0	0	0	0	(1,440)	31
32	Interest	(66,386)	0	0	0	0	0	0	0	0	0	0	(66,386)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(67,826)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(67,826)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	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):*	(29,299)	0	0	0	0	0	0	0	0	0	0	(29,299)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(29,299)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,299)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(195,318)</b>	<b>(73,824)</b>	<b>0</b>	<b>(269,142)</b>	<b>45</b>								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities, Inc.	100.00%	See Page 6 -Supplemental				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Home Office	\$ 639,167	Covenant Retirement Communities, Inc.	100.00%	\$ 565,343	\$ (73,824)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 639,167			\$ 565,343	\$ * (73,824)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Non-Profit Board of Directors							2
3								3
4	Jon Aagaard, MD		Brandel Manor	Turlock , CA	Covenant Ministries			4
5	Sarah Bentley		Covenant Health Care Ctr - Northbrook	Northbrook, IL	of Benevolence	Chicago, IL	Corporate Office	5
6	Pamela Christensen		Colonial Acres Healthcare	Golden Valley, MN	Covenant Retirement			6
7	Kara Davis, MD		Covenant Shores HC	Mercer Island, WA	Communities	Skokie, IL	Home Office	7
8	Mark Eastburg		Covenant Village Care Center	Plantation, FL	Brandel Manor	Turlock, CA	Asst. Living	8
9	Marc Espinosa		Covenant Village of Turlock	Turlock, CA	Covenant Village			9
10	Donald Hodgkinson		Covenant Village of Colorado	Westminister, CO	of Northbrook	Northbrook, IL	Asst. & Ind. Living	10
11	Scott Macdonald		Covenant Health Care Ctr - Batavia	Batavia, IL	Covenant Villae			11
12	Matthew Manlove		Mount Miguel Covenant Village	Spring Valley, CA	of Golden Valley	Golden Valley, MN	Asst. & Ind. Living	12
13	Dale Rinard		The Samarkand	Santa Barbara, CA	Covenant Shores	Mercer Island, WA	Asst. & Ind. Living	13
14	Marlene Stante		Windsor Park Manor	Carol Stream, IL	Covenant Village			14
15	Andrew Vanover		Covenant Village of Great Lakes	Grand Rapids, MI	of Florida	Plantation, FL	Asst. & Ind. Living	15
16	Anne Vining				Covenant Village			16
17					of Turlock	Turlock, CA	Asst. & Ind. Living	17
18					Covenant Village			18
19					of Colorado	Westminister, CO	Asst. & Ind. Living	19
20					The Holmstad	Batavia, IL	Asst. & Ind. Living	20
21					Mount Miguel			21
22					Covenant Village	Spring Valley, CA	Asst. & Ind. Living	22
23					The Samarkand	Santa Barbara, CA	Asst. & Ind. Living	23
24					Windsor Park Manor	Carol Stream, IL	Asst. & Ind. Living	24
25					Covenant Village			25
26					of Great Lakes	Grand Rapids, MI	Asst. & Ind. Living	26
27					Covenant Home			27
28					of Chicago	Chicago, IL	Supportive Living	28
29					Est. of Windsor Park	Carol Stream, IL	Ind. Living	29
30					Cov. Care at Home		HH & Hospice	30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor # 0034652 Report Period Beginning: 02/01/17 Ending: 01/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652 Report Period Beginning: 02/01/17

Ending: 01/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Home Office	Operating Expenses	333,335,000	\$ 23,307,647	\$ 9,005,675	8,085,267	\$ 565,343	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				\$ 23,307,647	\$ 9,005,675		\$ 565,343	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor # 0034652 Report Period Beginning: 02/01/17 Ending: 01/31/18

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	2012A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2012	\$	\$		\$	7,300	1								
2	2017B Illinois Rev Bonds		X	Capital Imp. / Debt Refinance		2017					47,045	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Financing Assessment		X								3,996	6								
7	Loss on Ext. of Debt		X								8,045	7								
8												8								
9	TOTAL Facility Related						\$	\$			\$	66,386	9							
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(66,386)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	(66,386)	14							
15	TOTALS (line 9+line14)						\$	\$			\$		15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

\*\* 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 Park Manor**

# **0034652**

Report Period Beginning:

**02/01/17**

Ending:

**01/31/18**

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2017 report.		\$	<b>48,679</b>	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.)		\$	<b>48,004</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(675)</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>51,460</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,785</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013		<b>8</b>	
	2014	<b>42,993</b>	<b>9</b>	
	2015	<b>44,770</b>	<b>10</b>	
	2016	<b>50,908</b>	<b>11</b>	
	2017	<b>48,004</b>	<b>12</b>	
<b>Windsor Park Manor receives an allocation of the real estate tax bill that is assigned for the entire campus.</b>				

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02 - 31 - 405 - 019</u>	<u>Nursing Facility</u>	\$ <u>300,022.76</u>	\$ <u>48,004.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>300,022.76</u></u>	\$ <u><u>48,004.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?  X  YES   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

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

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

Facility Name & ID Number Windsor Park Manor

# 0034652 Report Period Beginning:

02/01/17 Ending:

01/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (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, CNA training facilities, etc.)

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

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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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

**XI. OWNERSHIP COSTS (continued)**

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37 HCC - Bed Lights, Faucet, Grab Bars, Plumbing Fixtures, Painting, Tile,		\$	\$		\$	\$	\$
38 Flooring, Vanity, Vinyl Base, Windos, Blinds, Doors, HVAC Unit,							
39 Resident Rooms (129, 130)	2017	51,084					
40 HCC - Flooring (Nurses Station)	2017	13,100					
41 HCC - Heat Pump (Conference Room)	2017	5,805					
42 HCC - Cooling Tower	2017	18,563					
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65 Disposals		(163,303)					
66							
67							
68 Depreciation - Windsor Park Manor			526,066		526,066		5,983,561
69							
70 TOTAL (lines 4 thru 69)		\$ 8,860,731	\$ 526,066		\$ 526,066	\$	\$ 5,983,561

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,675,916	\$	\$	\$		\$	71
72	Current Year Purchases	79,995						72
73	Fully Depreciated Assets							73
74	Disposals	(345,408)						74
75	TOTALS	\$ 1,410,503	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,271,234	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 526,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 526,066	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,983,561	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning: 02/01/17

Ending: 01/31/18

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.  YES  NO

		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	<b>TOTAL</b>				\$			7

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.	<u>2019</u>	\$ _____
13.	<u>2020</u>	\$ _____
14.	<u>2021</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?  YES  NO
16. Rental Amount for movable equipment: \$ 9,117 Description: See Supplemental 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					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/17 - 01/31/18

Page 14 Supplemental Schedule

Description	Amount	Total
<b>Building Rental</b>		
N/A		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
<b>Total</b>	-	-

<b>Equipment Rental</b>		
		-
Pitney Bowes (Postage)	800	800
Konica Minolta (Copier)	8,317	8,317
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
<b>Total</b>	9,117	9,117

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

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

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

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	334,431	\$		\$	334,431	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					33,098				33,098	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs					537,411				537,411	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						257,874			257,874	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify): See Supplemental	39 - 02							75,276			75,276	12
13	Other (specify): See Supplemental	39 - 03							80,106			80,106	13
14	TOTAL			\$			\$	985,046	\$	333,150	\$	1,318,196	14

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

SEE ACCOUNTANTS' PREPARATION REPORT



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

# 0034652  
 As of 01/31/18

Report Period Beginning: 02/01/17  
 (last day of reporting year)

Ending: 01/31/18

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>37,719</u> )	954,738		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,048		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 967,786	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,488,098		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,797,945		16
17	Accumulated Depreciation (book methods)	(5,983,561)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,571		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,895)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	16,232,174		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 20,540,332	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 21,508,118	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 121,392	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,460		32
33	Accrued Interest Payable	3,107		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 175,959	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,037,525		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Supplemental Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,037,525	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,213,484	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 20,294,634	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 21,508,118	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/17 - 01/31/18

Page 17 Supplemental Schedule

Description	Operating	Building	Total
<b>Line 9 - Other Current Assets</b>			
			-
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 23 - Long Term Assets</b>			
Benevolent Care Fund	12,758		12,758
Debt Service / Bond Sinking Fund	461,023		461,023
Asset Clearing	96,906		96,906
Endowment Fund	1,985,449		1,985,449
Intercompany Transfer	13,676,038		13,676,038
<b>Sub-Total</b>	<u>16,232,174</u>	<u>-</u>	<u>16,232,174</u>
<b>Line 36 - Other Current Liability</b>			
			-
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>
<b>Line 43 - Long term Liabilities</b>			
			-
			-
			-
			-
			-
<b>Sub-Total</b>	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,846,357	1
2	Restatements (describe):		2
3	<u>Rounding</u>	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,846,361	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,248,422	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,248,422	17
<b>B. Transfers (Itemize):</b>			
18	<u>Restricted Net Asset Transfer</u>	199,851	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 199,851	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 20,294,634	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,227,137	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,227,137	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,637	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 178,637	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,301	13
14	Non-Patient Meals	5,195	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 20,496	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	415,867	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 415,867	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	3,179	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,179	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,845,316	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,192,497	31
32	Health Care	3,152,099	32
33	General Administration	2,166,585	33
<b>B. Capital Expense</b>			
34	Ownership	653,794	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,362,796	35
36	Provider Participation Fee	69,123	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,596,894	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,248,422	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,248,422	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 497,177	44
45	Private Pay - Net Inpatient Revenue	4,742,646	45
46	Medicare - Net Inpatient Revenue	3,362,642	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	624,013	47
48	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	659	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,227,137	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Windsor Park Manor

# 0034652

Report Period Beginning:

02/01/17

Ending:

01/31/18

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	1,719	2,010	\$ 111,212	\$ 55.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,254	27,552	1,012,724	36.76	3
4	Licensed Practical Nurses	12,840	14,611	401,569	27.48	4
5	CNAs & Orderlies	62,695	68,748	1,071,265	15.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	2,132	52,740	24.74	9
10	Activity Assistants	3,891	4,312	60,157	13.95	10
11	Social Service Workers	5,590	5,981	152,313	25.47	11
12	Dietician					12
13	Food Service Supervisor	456	509	11,352	22.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,438	24,036	301,297	12.54	15
16	Dishwashers					16
17	Maintenance Workers	1,824	2,167	45,728	21.10	17
18	Housekeepers	8,019	9,005	111,791	12.41	18
19	Laundry	1,439	1,514	18,029	11.91	19
20	Administrator	1,312	1,428	73,553	51.51	20
21	Assistant Administrator					21
22	Other Administrative	248	269	20,913	77.74	22
23	Office Manager					23
24	Clerical	8,856	9,698	235,222	24.25	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	1,938	2,165	55,840	25.79	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,414	1,462	27,208	18.61	33
34	TOTAL (lines 1 - 33)	161,851	177,599	\$ 3,762,913 *	\$ 21.19	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 2,271	01 - 03	35
36	Medical Director	36,000	09 - 03	36
37	Medical Records Consultant	915	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,188	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	520	11 - 03	44
45	Social Service Consultant	2,261	12 - 03	45
46	Other(specify)			46
47	See Supplemental Schedule	141,230		47
48				48
49	TOTAL (lines 35 - 48)	\$ 188,385		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	480	10 - 03	52
53	TOTAL (lines 50 - 52)	\$ 480		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

\*\* See instructions.

Windsor Park Manor  
 Medicaid Cost Report  
 02/01/17 - 01/31/18

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
<b>Nursing Home Employees</b>							
Transportation	14	1,155	1,171	17,193	14.68		
Fundraising	43	259	291	10,015	34.42		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
<b>Total</b>		<u>1,414</u>	<u>1,462</u>	<u>27,208</u>	<u>49.10</u>		

<b>Contracted Services</b>							
Dietary Management	01						134,905
Chaplain	12						6,325
<b>Total</b>							<u>-</u> <u>141,230</u>

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Lynn Blackburn	Administrator	0	\$ 73,553	Workers' Compensation Insurance	\$ 124,642	IDPH License Fee	\$ 1,990		
Andrew Clauson	Exec. Dir.	0	20,913	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	2,985		
				FICA Taxes	266,694	Health Care Worker Background Check	5,331		
				Employee Health Insurance	416,231	(Indicate # of checks performed )			
				Employee Meals		<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	22,263		
				Retirement Benefits	118,165	<u>Licenses and Permits</u>	2,877		
				Group Life and Disability Insurance	6,926				
				Other Benefits	8,293				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,466			Less: Public Relations Expense	( )		
B. Administrative - Other						Non-allowable advertising	( )		
Description			Amount			Yellow page advertising	( )		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 940,951	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 35,446
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
Cov. Ret. Communities, Inc.	Home Office		639,167						
Plante & Moran, PLLC	Audit		4,200						
SHBK	Consulting		1,008				In-State Travel		
Erickson Peterson Cramer	Consulting		1,361						
Marcum LLP	Consulting		194						
National Research	Consulting		327						
FGMK	Consulting		988				Seminar Expense	934	
Jeremy Brune & Assoc. LLC	Consulting		7,200				Non-Allowable	(23)	
Mix Solutions	Consulting		10,425						
Holeran Consulting	Consulting		2,480						
Polaris Group	Consulting		5,376				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 672,726	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 911

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Leading Age
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,983 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,123  
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? Yes Indicate the amount. \$ 5,195
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? Ln. 14
  - d. Have vehicle usage logs been maintained? Yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Plante & Moran, PLLC (Consolidated Basis)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT