

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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>0031823</u></p> <p>Facility Name: <u>WINDMILL NURSING PAVILION</u></p> <p>Address: <u>16000 S. WABASH</u> <u>SOUTH HOLLAND</u> <u>60473</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u></p> <p>IDPA ID Number: <u>36-3485403</u></p> <p>Date of Initial License for Current Owners: <u>01/02/87</u></p> <p>Type of Ownership:</p> <table border="0"> <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>01/01/2001</u> to <u>12/31/2001</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"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>MARSHALL MAUER</u></td> </tr> <tr> <td data-bbox="1144 828 1281 885"></td> <td data-bbox="1281 828 1921 885">(Title) <u>TREASURER</u></td> </tr> <tr> <td data-bbox="1144 885 1281 1039">Paid Preparer</td> <td data-bbox="1281 885 1921 1039">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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>MARSHALL MAUER</u>		(Title) <u>TREASURER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 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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Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF			2,021	2,021	8
9	SNF/PED					9
10	ICF	43,532	2,029	597	46,158	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,532	2,029	2,618	48,179	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.00%

D. How many bed-hold days during this year were paid by Public Aid? 509 (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 01/02/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/2/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 1,631

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	174,315	14,477	6,266	195,058		195,058	0	195,058		1
2	Food Purchase		206,347		206,347	(27,156)	179,191	(685)	178,506		2
3	Housekeeping	13,165	18,860	0	32,025		32,025	0	32,025		3
4	Laundry	0	11,908	73,986	85,894		85,894	0	85,894		4
5	Heat and Other Utilities			102,412	102,412		102,412	883	103,295		5
6	Maintenance	55,430	25,457	144,135	225,022		225,022	15,636	240,658		6
7	Other (specify):*			11,790	11,790		11,790	1,344	13,134		7
8	TOTAL General Services	242,910	277,049	338,589	858,548	(27,156)	831,392	17,178	848,570		8
	B. Health Care and Programs										
9	Medical Director	0		600	600		600	0	600		9
10	Nursing and Medical Records	1,665,385	52,786	69,437	1,787,608		1,787,608	(515)	1,787,093		10
10a	Therapy	0	740	18,660	19,400		19,400	0	19,400		10a
11	Activities	98,446	7,737	1,935	108,118		108,118	0	108,118		11
12	Social Services	20,544		6,347	26,891		26,891	0	26,891		12
13	Nurse Aide Training			0	0		0	138	138		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,784,375	61,263	96,979	1,942,617	0	1,942,617	(377)	1,942,240		16
	C. General Administration										
17	Administrative	99,901		120,000	219,901		219,901	68,976	288,877		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			46,237	46,237		46,237	3,888	50,125		19
20	Dues, Fees, Subscriptions & Promotions			50,317	50,317		50,317	(34,739)	15,578		20
21	Clerical & General Office Expenses	109,477	16,975	241,079	367,531		367,531	(168,739)	198,792		21
22	Employee Benefits & Payroll Taxes			391,817	391,817	27,156	418,973	0	418,973		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			2,200	2,200		2,200	985	3,185		24
25	Other Admin. Staff Transportation			2,255	2,255		2,255	125	2,380		25
26	Insurance-Prop.Liab.Malpractice			116,325	116,325		116,325	3,979	120,304		26
27	Other (specify):*			0	0		0	25,466	25,466		27
28	TOTAL General Administration	209,378	16,975	970,230	1,196,583	27,156	1,223,739	(100,059)	1,123,680		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,236,663	355,287	1,405,798	3,997,748	0	3,997,748	(83,258)	3,914,490		29

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

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

Facility Name & ID Number

WINDMILL NURSING PAVILION

#0031823

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			65,767	65,767		65,767	97,965	163,732		30
31	Amortization of Pre-Op. & Org.				0		0	0	0		31
32	Interest			14,005	14,005		14,005	482,138	496,143		32
33	Real Estate Taxes			253,044	253,044		253,044	2,081	255,125		33
34	Rent-Facility & Grounds			958,200	958,200		958,200	(958,200)	0		34
35	Rent-Equipment & Vehicles			5,669	5,669		5,669	8,516	14,185		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			1,296,685	1,296,685	0	1,296,685	(367,500)	929,185		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		53,206	82,391	135,597		135,597	(3,427)	132,170		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			82,125	82,125		82,125	0	82,125		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	53,206	164,516	217,722	0	217,722	(3,427)	214,295		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,236,663	408,493	2,866,999	5,512,155	0	5,512,155	(454,185)	5,057,970		45

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

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(94,495)	30		9
10	Interest and Other Investment Income	(1,518)	32		10
11	Discounts, Allowances, Rebates & Refunds	(156)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(529)	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	0	20		17
18	Fines and Penalties	(6,880)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,750)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(349)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(33,196)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	5,602			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,271)		\$ 0	30

OHF USE ONLY					
48		49	50	51	52

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

		1	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)	(319,914)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (319,914)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (454,185)		37

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

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

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

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 5602	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	5,602	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning:

01/01/2001 Ending: 12/31/2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(685)	0	0	0	0	0	0	0	0	0	0	(685)	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	883	0	0	0	0	0	0	0	0	883	5
6	Maintenance	5,602	0	4,576	5,458	0	0	0	0	0	0	0	15,636	6
7	Other (specify):*	0	0	945	0	399	0	0	0	0	0	0	1,344	7
8	TOTAL General Services	4,917	0	6,404	5,458	399	0	0	0	0	0	0	17,178	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	(515)	0	0	0	0	0	(515)	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	138	0	0	0	0	0	0	0	0	138	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	138	0	0	(515)	0	0	0	0	0	(377)	16
	C. General Administration													
17	Administrative	0	(100,800)	0	169,776	0	0	0	0	0	0	0	68,976	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(349)	2,250	1,987	0	0	0	0	0	0	0	0	3,888	19
20	Fees, Subscriptions & Promotions	(35,946)	0	1,207	0	0	0	0	0	0	0	0	(34,739)	20
21	Clerical & General Office Expenses	(6,880)	(211,000)	49,141	0	0	0	0	0	0	0	0	(168,739)	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	985	0	0	0	0	0	0	0	0	985	24
25	Other Admin. Staff Transportation	0	0	125	0	0	0	0	0	0	0	0	125	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,979	0	0	0	0	0	0	0	0	3,979	26
27	Other (specify):*	0	0	7,925	0	17,541	0	0	0	0	0	0	25,466	27
28	TOTAL General Administration	(43,175)	(309,550)	65,349	169,776	17,541	0	0	0	0	0	0	(100,059)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,258)	(309,550)	71,891	175,234	17,940	(515)	0	0	0	0	0	(83,258)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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)
	D. Ownership												
30	Depreciation	(94,495)	188,716	3,744	0	0	0	0	0	0	0	0	97,965 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,518)	481,514	2,142	0	0	0	0	0	0	0	0	482,138 32
33	Real Estate Taxes	0	0	2,081	0	0	0	0	0	0	0	0	2,081 33
34	Rent-Facility & Grounds	0	(958,200)	0	0	0	0	0	0	0	0	0	(958,200) 34
35	Rent-Equipment & Vehicles	0	0	8,516	0	0	0	0	0	0	0	0	8,516 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(96,013)	(287,970)	16,483	0	0	0	0	0	0	0	0	(367,500) 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	(3,427)	0	0	0	0	0	(3,427) 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	(3,427)	0	0	0	0	0	(3,427) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(134,271)	(597,520)	88,374	175,234	17,940	(3,942)	0	0	0	0	0	(454,185) 45

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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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	17	MANAGEMENT FEE	\$ 100,800	DYNAMIC HEALTHCARE CONSULTANTS		(100,800)	1
2	V	21	BOOKKEEPING SVC	211,000	" " "		(211,000)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34	RENT	958,200	16000 S. WABASH LIMITED PARTNERSHIP		(958,200)	7
8	V	19	ACCOUNTING FEES		" " "	2,250	2,250	8
9	V	30	DEPRECIATION		" " "	188,716	188,716	9
10	V	32	INTEREST		" " "	481,514	481,514	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,270,000			\$ 672,480	\$ * (597,520)	14

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

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	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 883	\$ 883
16	V	6 REPAIRS & MAINT.		" " "	100.00%	4,576	4,576
17	V	7 EMP. BEN. - GEN. SERVICES		" " "	100.00%	945	945
18	V	13 NURSES AIDE TRAINING		" " "	100.00%	138	138
19	V	19 PROFESSIONAL FEES		" " "	100.00%	1,987	1,987
20	V	20 DUES AND SUBSCRIPTION		" " "	100.00%	1,207	1,207
21	V	21 CLERICAL & GENERAL		" " "	100.00%	49,141	49,141
22	V	24 SEMINARS AND TRAVEL		" " "	100.00%	985	985
23	V	25 ADMIN. STAFF TRANS		" " "	100.00%	125	125
24	V	26 INSURANCE		" " "	100.00%	3,979	3,979
25	V	27 EMP BEN. - GEN ADMIN.		" " "	100.00%	7,925	7,925
26	V	30 DEPRECIATION		" " "	100.00%	3,744	3,744
27	V	32 INTEREST		" " "	100.00%	2,142	2,142
28	V	33 REAL ESTATE TAXES		" " "	100.00%	2,081	2,081
29	V	35 EQUIPMENT RENTAL		" " "	100.00%	8,516	8,516
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 88,374	\$ * 88,374

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

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6	MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 5,458	\$ 5,458	15
16	V	10	NURSING CMP - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	33,900	33,900	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	45,789	45,789	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	42,600	42,600	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	11,019	11,019	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	11,877	11,877	25
26	V	17	ADMIN. CMP. - H. ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	19,234	19,234	27
28	V	17	CLERICAL CMP. - S. AARON		" " "	100.00%	5,357	5,357	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		\$				\$ 175,234	\$ * 175,234	39

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

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7	EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 399	\$ 399	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	2,164	2,164	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	3,157	3,157	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	4,895	4,895	19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	2,371	2,371	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,649	1,649	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	2,586	2,586	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	719	719	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		\$				\$ 17,940	\$ * 17,940	39

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

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	10a THERAPY	\$ 16,020	DYNAMIC REHAB CONSULTANTS LLC	100.00%	\$ 16,020	\$
16	V	19 PROFESSIONAL FEES		" "	100.00%		
17	V	22 EMPLOYEE BENEFITS		" "	100.00%		
18	V	39 ANCILLARY SERVICES	79,808	" "	100.00%	79,808	
19	V						
20	V	10 NURSING & MEDICAL SUPP	13,153	PHARMCOR LLC	100.00%	13,153	
21	V	19 PROFESSIONAL FEES		" "	100.00%		
22	V	21 CLERICAL & GENERAL	165	" "	100.00%	165	
23	V	22 EMPLOYEE BENEFITS		" "	100.00%		
24	V	39 ANCILLARY EXPENSE	31,425	" "	100.00%	31,425	
25	V						
26	V				100.00%		
27	V	10 MEDICAL SUPPLIES	2,487	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,972	(515)
28	V	39 ANCILLARY EXPENSE	16,551	" "	100.00%	13,124	(3,427)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 159,609			\$ 155,667	\$ * (3,942)

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	\$ 33,900	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	45,789	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	42,600	17-7	3
4	" "		ADMINISTRATIVE					MGMT FEE	19,200	17-3	4
5											5
6	SHARON AARON		CLERICAL					SALARY	5,357	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 146,846		13

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

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847)679-7377

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	TOTAL PATIENT DAYS	577,359	14	\$ 10,580	\$	48,179	\$ 883	1
2	6 REPAIRS & MAINT	" "	577,359	14	54,834	37,633	48,179	4,576	2
3	7 EMP. BEN. - GEN. SVC.	" "	577,359	14	11,326		48,179	945	3
4	13 NURSES AIDE TRAINING	" "	577,359	14	1,650		48,179	138	4
5	19 PROFESSIONAL FEES	" "	577,359	14	23,811		48,179	1,987	5
6	20 DUES & SUBSCRIPTIONS	" "	577,359	14	14,469		48,179	1,207	6
7	21 CLERICAL & GENERAL	" "	577,359	14	588,891	487,646	48,179	49,141	7
8	24 SEMINARS & TRAVEL	" "	577,359	14	11,803		48,179	985	8
9	25 ADMIN. STAFF TRANS.	" "	577,359	14	1,502		48,179	125	9
10	26 INSURANCE	" "	577,359	14	47,685		48,179	3,979	10
11	27 EMP.BEN. - GEN. ADMIN.	" "	577,359	14	94,969		48,179	7,925	11
12	30 DEPRECIATION	" "	577,359	14	44,866		48,179	3,744	12
13	32 INTEREST	" "	577,359	14	25,667		48,179	2,142	13
14	33 REAL ESTATE TAXES	" "	577,359	14	24,936		48,179	2,081	14
15	35 EQUIPMENT RENTAL	" "	577,359	14	102,054		48,179	8,516	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,059,043	\$ 525,279		\$ 88,374	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2001

Ending: 2/31/2001

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WEIGHTED HOURS	40	12	\$ 62,194	\$ 62,194	4	\$ 5,458	1
2	10	NURSING CMP - SUE G.	" " "	40	1	45,894	45,894		0	2
3	17	ADMIN. CMP. - M. MAUER	" " "	40	13	398,821	398,821	3	33,900	3
4	17	ADMIN. CMP. - M. AARON	" " "	45	12	521,536	521,536	4	45,789	4
5	17	ADMIN. CMP. - F. AARON	" " "	45	6	191,700	191,700	10	42,600	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" " "	50	3	161,003	161,003		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" " "	45	8	71,993	71,993		0	7
8	17	ADMIN. CMP. - D. MAGAFAS	" " "	45	8	81,938	81,938	6	11,019	8
9	17	ADMIN. CMP. - E. CASSON	" " "	37.5	1	47,846	47,846		0	9
10	17	ADMIN. CMP. - S. BOGEN	" " "	45	3	96,858	96,858		0	10
11	17	ADMIN. CMP. - S. LEVY	" " "	55	13	139,807	139,807	5	11,877	11
12	17	ADMIN. CMP. - H. ALTER	" " "	40	1	9,000	9,000		0	12
13	17	ADMIN. CMP. - NON-OWNER	" " "	45	13	219,069	219,069	4	19,234	13
14	17	CLERICAL CMP. - S. AARON	" " "	40	13	63,022	63,022	3	5,357	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,110,681	\$ 2,110,681		\$ 175,234	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847)679-7377

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WEIGHTED HOURS	40	12	\$ 4,545	\$ 4	\$ 399	1
2	15	EMP. BEN. - SUE G.	" " "	40	1	3,924		0	2
3	27	EMP. BEN. - M. MAUER	" " "	40	13	25,461	3	2,164	3
4	27	EMP. BEN. - M. AARON	" " "	45	12	35,957	4	3,157	4
5	27	EMP. BEN. - F. AARON	" " "	45	6	22,028	10	4,895	5
6	27	EMP. BEN. - S. GOLDSTEIN	" " "	50	3	20,193		0	6
7	27	EMP. BEN. - S. KOPLIN	" " "	45	8	16,504		0	7
8	27	EMP. BEN. - D. MAGAFAS	" " "	45	8	17,632	6	2,371	8
9	27	EMP. BEN. - E. CASSON	" " "	37.5	1	11,976		0	9
10	27	EMP. BEN. - S. BOGEN	" " "	45	3	6,849		0	10
11	27	EMP. BEN. - S. LEVY	" " "	55	13	19,408	5	1,649	11
12	27	EMP. BEN. - H. ALTER	" " "	40	1	1,068		0	12
13	27	EMP. BEN. - NON-OWNER	" " "	45	13	29,449	4	2,586	13
14	27	EMP. BEN. - S. AARON	" " "	40	13	8,457	3	719	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 223,451	\$	\$ 17,940	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

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 DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847)679-7377

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10a	THERAPY	DIRECT ALLOCATION		\$	\$		16,020	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION					79,808	4
5									5
6	10	NURSING & MEDICAL SUPP	DIRECT ALLOCATION					13,153	6
7	19	PROFESSIONAL FEES	DIRECT ALLOCATION						7
8	21	CLERICAL & GENERAL	DIRECT ALLOCATION					165	8
9	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						9
10	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					31,425	10
11									11
12									12
13	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					1,972	13
14	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					13,124	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		155,667	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	AMERICAN NATIONAL BANK	X		MORTGAGE	\$55,898.81	10/00	\$ 5,625,000	\$ 5,408,052			8.6500	\$ 481,514	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	AMERICAN NATIONAL BANK	X		WORKING CAPITAL				350,000			PRIME+	14,005	6						
7													7						
8													8						
9	TOTAL Facility Related				\$55,898.81		\$ 5,625,000	\$ 5,758,052				\$ 495,519	9						
	B. Non-Facility Related*																		
10	IRS, IDR, ETC	X		LATE FEES									10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0				\$ 0	14						
15	TOTALS (line 9+line14)						\$ 5,625,000	\$ 5,758,052				\$ 495,519	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.)

Facility Name & ID Number **WINDMILL NURSING PAVILION**# **0031823** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****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 2000 report.			\$	242,000	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.)			\$	244,044	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	2,044	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	251,000	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	253,044	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	224,885	8	FOR OHF USE ONLY	
		1997	224,837	9	13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
		1998	232,380	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		1999	237,206	11	15	LESS REFUND FROM LINE 6 \$ 15
		2000	244,044	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
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 2000 TAX BILL.						

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>29-15-302-051-0000</u>	<u>NURSING HOME</u>	\$ <u>244,044.38</u>	\$ <u>244,044.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>244,044.38</u>	\$ <u>244,044.38</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? YES NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning:

01/01/2001 Ending:

12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____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			\$ 354,221	1
2					2
3	TOTALS			\$ 354,221	3

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XL 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	150	1986	1976	\$ 3,187,988	\$ 188,716	30	\$ 106,266	\$ (82,450)	\$ 1,487,724	4
5										5
6										6
7										7
8				37,017	949	35	1,058	109	8,813	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1989	6,334	201	31.5	201		2,504	9
10	LEASEHOLD IMPROVEMENT		1990	1,538	49	20	77	28	653	10
11	LEASEHOLD IMPROVEMENT		1991	26,695	848	20	1,335	487	10,852	11
12	LEASEHOLD IMPROVEMENT		1992	4,785	152	20	239	87	1,792	12
13	LEASEHOLD IMPROVEMENT		1993	8,024	255	31.5	255		2,235	13
14	LEASEHOLD IMPROVEMENT		1993	36,822	944	39	944		7,893	14
15	LEASEHOLD IMPROVEMENT		1994	38,826	996	39	996		7,165	15
16	LEASEHOLD IMPROVEMENT		1995	21,539	553	39	553		3,684	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996	1,604	41	39	41		238	17
18	ROOF REPAIR		1996	3,800	97	39	97		530	18
19	GAZEBO		1996	1,282	33	39	33		177	19
20	ASPHALT REMOVE & REPLACE		1996	2,686	69	39	69		366	20
21	ROOF REPAIR		1996	7,000	179	39	179		947	21
22	HOT WATER TANK		1996	12,098	310	39	310		1,589	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997	6,844	175	39	175		751	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997	105,092	2,695	39	2,695		11,636	24
25	ROOFING		1997	45,500	1,167	39	1,167		5,009	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997	4,721	121	39	121		519	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997	26,497	679	39	679		2,914	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998	3,359	86	39	86		295	28
29	DRAPES & INSTALLATION		1998	5,965	153	39	153		514	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998	14,240	365	39	365		1,229	30
31	EXHAUST FAN & INSTALLATION		1998	2,285	59	39	59		189	31
32	ROOF REPAIR		1998	8,750	224	39	224		758	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998	22,500	577	39	577		1,963	33
34	ELECTRICAL WORK		1998	5,376	138	39	138		463	34
35	COUNTER TOPS		1998	712	18	39	18		60	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT IMPROVEMENT	1999	\$ 1,185	\$ 30	39	\$ 30	\$	\$ 90	37
38	NURSES STATION	1999	16,601	426	39	426		1,261	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		264	39
40	FIRE SYSTEM	1999	2,625	67	39	67		197	40
41	FLOOR TILE	1999	10,807	277	39	277		820	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		670	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		565	43
44	AIR CONDITIONING	1999	14,451	371	39	371		1,000	44
45	RAILINGS	1999	3,282	84	39	84		221	45
46	ROOF WORK	1999	4,500	115	39	115		264	46
47	NURSE STATION	2000	7,090	258	27.5	258		399	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		361	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		477	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		145	50
51	SMOKE DETECTOR	2000	3,472	126	27.5	126		194	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	209	15	209		209	52
53	DOORS, DOOR RELEASE	2001	5,661	78	27.5	78		78	53
54	ROOF REPAIRS	2001	5,750	83	27.5	83		83	54
55	WALL AIRCONDITINER	2001	2,913	37	27.5	37		37	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	81	27.5	81		81	56
57	SINK, SHELVES, CASES	2001	2,423	30	27.5	30		30	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,783,123	\$ 204,345		\$ 122,606	\$ (81,739)	\$ 1,570,908	70

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

C. Equipment Depreciation-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	\$ 393,602	\$ 47,302	\$ 35,946	\$ (11,356)		\$ 170,262	71
72	Current Year Purchases	32,584	3,805	1,629	(2,176)		1,629	72
73	Fully Depreciated Assets	119,274	0		0		119,274	73
74	RELATED PARTY	21,984	2,539	2,098	(441)		11,796	74
75	TOTALS	\$ 567,444	\$ 53,646	\$ 39,673	\$ (13,973)		\$ 302,961	75

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	
76	RELATED PARTY			\$ 4,698	\$ 255	\$ 1,472	\$ 1,217		\$ 1,693	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 4,698	\$ 255	\$ 1,472	\$ 1,217		\$ 1,693	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)	\$ 4,709,486	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 258,246	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,751	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (94,495)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,875,562	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
 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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</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: \$ 5,669 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	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.

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?</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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)

		Facility			
		1 Drop-outs	2 Completed	3 Contract	4 Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (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.

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	Licensed Occupational Therapist		hrs	\$		\$ 18,659	\$	\$	18,659	1
2	Licensed Speech and Language Development Therapist		hrs			1,111			1,111	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			59,589			59,589	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				33,177		33,177	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, XRAY, MEDICAL SUPPLIES Other (specify):					3,032	20,029		23,061	13
14	TOTAL			\$		\$ 82,391	\$ 53,206	\$	135,597	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.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 33,299	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,061,702		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	46,125		6
7 Other Prepaid Expenses	3,790		7
8 Accounts Receivable (owners or related parties)	51,000		8
9 Other(specify): EMP WAGE ASSIGNMENT	3,759		9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,199,675	\$ 0	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	558,118		15
16 Equipment, at Historical Cost	568,962		16
17 Accumulated Depreciation (book methods)	(511,002)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 616,078	\$ 0	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,815,753	\$ 0	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 337,190	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	350,000		29
30 Accrued Salaries Payable	257,081		30
31 Accrued Taxes Payable (excluding real estate taxes)	17,922		31
32 Accrued Real Estate Taxes(Sch.IX-B)	251,000		32
33 Accrued Interest Payable	460		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,213,653	\$ 0	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,213,653	\$ 0	46
47 TOTAL EQUITY (page 18, line 24)	\$ 602,100	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,815,753	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 797,960	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(7,507)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 790,453	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,353)	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	(126,000)	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)	\$ (188,353)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 602,100	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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	\$ 5,346,970	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,346,970	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,158	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 101,158	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)	\$ 0	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,518	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,518	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	156	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 156	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,449,802	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	858,548	31
32	Health Care	1,942,617	32
33	General Administration	1,196,583	33
B. Capital Expense			
34	Ownership	1,296,685	34
C. Ancillary Expense			
35	Special Cost Centers	135,597	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,512,155	40
41	Income before Income Taxes (line 30 minus line 40)**	(62,353)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (62,353)	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.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

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	1,949	2,206	\$ 64,286	\$ 29.14	1
2	Assistant Director of Nursing	3,309	3,603	76,253	21.16	2
3	Registered Nurses	2,399	2,395	45,858	19.15	3
4	Licensed Practical Nurses	39,018	41,875	725,786	17.33	4
5	Nurse Aides & Orderlies	76,990	82,026	735,213	8.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	166	166	1,989	11.98	9
10	Activity Assistants	11,681	12,830	96,457	7.52	10
11	Social Service Workers	1,535	1,669	20,544	12.31	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,206	29,818	13.52	13
14	Head Cook	3,616	3,863	34,266	8.87	14
15	Cook Helpers/Assistants	14,052	15,363	110,231	7.18	15
16	Dishwashers					16
17	Maintenance Workers	4,162	4,541	55,430	12.21	17
18	Housekeepers	2,413	2,200	13,165	5.98	18
19	Laundry					19
20	Administrator	1,885	2,158	60,877	28.21	20
21	Assistant Administrator	2,065	2,334	39,024	16.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,242	9,010	109,477	12.15	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	1,766	1,946	17,989	9.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,237	190,391	\$ 2,236,663 *	\$ 11.75	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	MONTHLY	\$ 5,772	1-3	35
36	Medical Director	MONTHLY	600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	MONTHLY	1,712	10-3	38
39	Pharmacist Consultant	180	4,021	10-3	39
40	Physical Therapy Consultant	144	11,450	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	159	1,935	11-3	44
45	Social Service Consultant	MONTHLY	6,347	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	483	\$ 31,837		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	3,887	63,704	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,887	\$ 63,704		53

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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		
ANN MARIE HARRINGTON	ADMIN	0	\$ 60,877	Workers' Compensation Insurance	\$ 50,339	IDPH License Fee	\$ 200		
JOYCE MCGEE	ASST ADMIN	0	39,024	Unemployment Compensation Insurance	20,723	Advertising: Employee Recruitment	5,023		
				FICA Taxes	169,762	Health Care Worker Background Check	476		
				Employee Health Insurance	143,779	(Indicate # of checks performed _____)			
				Employee Meals	27,156	MARKETING/ADV/PROMO	33,196		
				Illinois Municipal Retirement Fund (IMRF)*		RELATED PARTY	1,207		
				EMPLOYEE BENEFITS - OTHER	7,214	CONTRIBUTIONS	2,750		
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	7,597		
				PENSION/PROFIT SHARING PLANS	0	LICENSES & PERMITS	1,075		
				CHICAGO HEAD TAX	0	CONTRIBUTIONS	(2,750)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(33,196)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 99,901	TOTAL (agree to Schedule V, line 22, col.8)	\$ 418,973	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,578		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
DYNAMIC HEALTHCARE			\$ 100,800				Out-of-State Travel	\$	
FRED AARON			19,200				In-State Travel		
								0	
							RELATED PARTY	985	
							Seminar Expense		
								2,200	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,000				Entertainment Expense	()	
(Attach a copy of any management service agreement)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	\$ 3,185
C. Professional Services									
Vendor/Payee	Type		Amount						
Health Data System	Data Processing		\$ 3,162						
Sachnoff and Weaver	Legal		4,396						
Finkel, Martwick and Colson	Legal		3,089						
Krupnick, Bokor, Kagda	Accounting		13,567						
Frost, Ruttenberg	Accounting		4,755						
Econocare	Purchasing Consultant		2,700						
Personal Planners	UC Consultant		970						
Fox River Food	Purchasing Consultant		1,000						
Dart Chart System	Medicare Consultant		12,024						
Genesis Computer	Computer		225						
Edelstein & Edelstein	Account Collection Fee		349						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 46,237						
(If total legal fees exceed \$2500 attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
1	PAINT/DECORATING	1997	\$ 52,354	3	\$ 17,451	\$ 17,451	\$ 8,726	\$	\$	\$	\$	\$
2	PAINT/DECORATING	1998	25,727	3	4,288	8,576	8,576	4,287				
3	PAINT/DECORATING	1999	3,946	3		658	1,315	1,315	658			
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 82,027		\$ 21,739	\$ 26,685	\$ 18,617	\$ 5,602	\$ 658	\$	\$	\$

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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 ON LONG TERM CARE \$2,975.
- (3) Did the nursing home make political contributions or payments to a political action 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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 292 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 82,125
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 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. \$ 27,156 Has any meal income been offset against related costs? NA Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,772
	REPAIRS & MAINTENANCE	494
		0
		6,266
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,212
	CONTRACTED LAUNDRY SERVICES	72,774
		73,986
5	HEAT & OTHER UTILITIES	
	GAS HEAT	33,228
	ELECTRICITY	52,743
	WATER	15,895
	CABLE TV - LOBBY	546
		0
		102,412
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,322
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,052
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,275
	FIRE SERVICE	0
	CONTRACTED BUILDING MAINTENANCE	132,486
		0
		0
		144,135
7	OTHER	
	SCAVENGER	11,790
	SECURITY SERVICE	0
		11,790
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	600
		600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	63,704
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	4,021
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,712
		0
		0
		69,437
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	7,210
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	11,450
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		18,660
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,935
		0
		1,935
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	6,347
		0
		6,347
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	120,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	3,162
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	42,726
	ACCOUNT COLLECTION FEE	349
20	FEES,SUBSCRIPTIONS,PROMOTIONS	46,237
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	33,196
	EMPLOYEE WANT ADS XIX F	5,023
	CONTRIBUTIONS VI 20 XIX F	150
	DUES & SUBSCRIPTIONS XIX F	7,597
	LICENSES & PERMITS XIX F	1,275
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,600
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	476
21	CLERICAL & GENERAL OFFICE EXPENSES	50,317
	BANK CHARGES	35
	EQUIPMENT REPAIR & MAINTENANCE	6,599
	OUTSIDE CLERICAL SERVICES	211,000
	PENALTIES / OVERDRAFT CHARGES VI 18	6,880
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,565
	MESSENGER SERVICE	0
		241,079

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	169,762
	UNEMPLOYMENT COMPENSATION XIX D	20,723
	WORKERS COMPENSATION INSURANC XIX D	50,339
	HOSPITALIZATION INSURANCE XIX D	143,779
	EMPLOYEE BENEFITS - OTHER XIX D	7,214
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
23	INSERVICE TRAINING & EDUCATION	391,817
	EDUCATION & SEMINARS	0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,200
	TRAVEL XIX G	0
		0
		2,200
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,255
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	116,325
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER 1,405,798

WINDMILL NURSING PAVILION
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	206,347
LESS SALES TAX	(529)

NET FOOD	205,818
TOTAL PATIENT CENSUS	48,179
TIME 3 MEALS PER DAY	3

TOTAL PATIENT MEALS	144537
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	365

TOTAL EMPLOYEE MEALS	21900

PATIENT MEALS	144537
ADD EMPLOYEE MEALS	21900

TOTAL MEALS/YEAR	166437
NET FOOD	205818
DIVIDE TOTAL MEALS/YEAR	166437
COST PER MEAL	1.24
TIME EMPLOYEE MEALS	21900

EMPLOYEE MEAL RECLASSIFICATION	27156
	=====