

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 SOUTH 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>HFS ID Number: <u>36-3485403</u></p> <p>Date of Initial License for Current Owners: <u>1/2/1987</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 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>01/01/2006</u> to <u>12/31/2006</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 rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>TREASURER</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____		(Title) <u>TREASURER</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	308	68	8,561	8,937	8
9	SNF/PED					9
10	ICF	38,704	2,951		41,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,012	3,019	8,561	50,592	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.41%

D. How many bed-hold days during this year were paid by the Department? 0 (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 01/02/87 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 4,734

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	219,863	19,291	9,237	248,391		248,391	0	248,391		1
2	Food Purchase		191,890		191,890	(24,090)	167,800	(501)	167,299		2
3	Housekeeping	0	23,521	143,758	167,279		167,279	0	167,279		3
4	Laundry	0	16,132	80,064	96,196	0	96,196	0	96,196		4
5	Heat and Other Utilities			134,226	134,226		134,226	1,311	135,537		5
6	Maintenance	60,025	41,691	14,474	116,190		116,190	14,119	130,309		6
7	Other (specify):*			12,366	12,366		12,366	760	13,126		7
8	TOTAL General Services	279,888	292,525	394,125	966,538	(24,090)	942,448	15,689	958,137		8
	B. Health Care and Programs										
9	Medical Director	0		600	600		600	0	600		9
10	Nursing and Medical Records	2,110,420	67,161	4,946	2,182,527		2,182,527	(1,960)	2,180,567		10
10a	Therapy	0	4,407	181	4,588		4,588	0	4,588		10a
11	Activities	98,895	7,541	1,848	108,284		108,284	0	108,284		11
12	Social Services	40,904		1,100	42,004		42,004	0	42,004		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	2,250,219	79,109	8,675	2,338,003	0	2,338,003	(1,960)	2,336,043		16
	C. General Administration										
17	Administrative	137,546		73,200	210,746		210,746	30,934	241,680		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			69,806	69,806		69,806	1,242	71,048		19
20	Dues, Fees, Subscriptions & Promotions			72,480	72,480		72,480	(56,780)	15,700		20
21	Clerical & General Office Expenses	180,596	13,335	342,630	536,561		536,561	(241,408)	295,153		21
22	Employee Benefits & Payroll Taxes			440,826	440,826	24,090	464,916	0	464,916		22
23	Inservice Training & Education			3,035	3,035		3,035	0	3,035		23
24	Travel and Seminar			0	0		0	222	222		24
25	Other Admin. Staff Transportation			255	255		255	1,272	1,527		25
26	Insurance-Prop.Liab.Malpractice			129,168	129,168		129,168	4,964	134,132		26
27	Other (specify):*			58,634	58,634		58,634	(27,117)	31,517		27
28	TOTAL General Administration	318,142	13,335	1,190,034	1,521,511	24,090	1,545,601	(286,671)	1,258,930		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,848,249	384,969	1,592,834	4,826,052	0	4,826,052	(272,942)	4,553,110		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,880
	REPAIRS & MAINTENANCE	357
		0
		9,237
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICE	143,758
		0
		143,758
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,099
	CONTRACTED LAUNDRY SERVICE	78,965
		0
		80,064
5	HEAT & OTHER UTILITIES	
	GAS HEAT	45,406
	ELECTRICITY	67,645
	WATER	20,438
	CABLE TV - LOBBY	737
		0
		134,226
6	MAINTENANCE	
	GROUND MAINTENANCE	5,571
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,328
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	0
		0
		0
		0
		0
		14,474
7	OTHER	
	SCAVENGER	12,366
	SECURITY SERVICE	0
		0
		0
		12,366
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	600
		600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	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	4,946
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		4,946
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	155
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	26
		181
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,848
		0
		1,848
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,100
		0
		1,100
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	73,200
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,858
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	63,948
		0
		69,806
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	54,132
	EMPLOYEE WANT ADS XIX F	1,918
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,985
	LICENSES & PERMITS XIX F	2,175
	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	3,480
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,010
	PATIENT BACKGROUND CHECKS XIX F	1,780
		72,480
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	694
	EQUIPMENT REPAIR & MAINTENANCE	9,428
	OUTSIDE CLERICAL SERVICES	314,450
	PENALTIES / OVERDRAFT CHARGES VI 18	147
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,911
	MESSENGER SERVICE	0
		0
		342,630

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	215,231
	UNEMPLOYMENT COMPENSATION XIX D	46,105
	WORKERS COMPENSATION INSURANC XIX D	85,285
	HOSPITALIZATION INSURANCE XIX D	84,678
	EMPLOYEE BENEFITS - OTHER XIX D	9,527
	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
		0
		440,826
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,035
		3,035
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	255
		255
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	129,168
		129,168
27	OTHER	
	BAD DEBTS VI 24	58,634
		58,634

GRAND TOTAL COLUMN 3 OTHER

1,592,834

WINDMILL NURSING PAVILION
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	191,890	PATIENT MEALS	151776
LESS SALES TAX	(501)	ADD EMPLOYEE MEALS	21900
	-----		-----
NET FOOD	191,389	TOTAL MEALS/YEAR	173676
TOTAL PATIENT CENSUS	50,592	NET FOOD	191389
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	173676

TOTAL PATIENT MEALS	151776	COST PER MEAL	1.1
		TIME EMPLOYEE MEALS	21900
ADD # EMPLOYEE MEALS/DAY	60		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	24090
	-----		=====
TOTAL EMPLOYEE MEALS	21900		

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			68,485	68,485		68,485	118,646	187,131			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			18,434	18,434		18,434	378,997	397,431			32
33	Real Estate Taxes			321,321	321,321		321,321	4,024	325,345			33
34	Rent-Facility & Grounds			960,700	960,700		960,700	(960,700)	0			34
35	Rent-Equipment & Vehicles			3,971	3,971		3,971	7,275	11,246			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,372,911	1,372,911	0	1,372,911	(451,758)	921,153			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		133,638	467,207	600,845		600,845	(1,486)	599,359			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	133,638	549,332	682,970	0	682,970	(1,486)	681,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,848,249	518,607	3,515,077	6,881,933	0	6,881,933	(726,186)	6,155,747			45

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

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	107,870	30		9
10	Interest and Other Investment Income	(4,842)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(501)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(147)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,480)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(397)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,634)	27		24
25	Fund Raising, Advertising and Promotional	(54,132)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,263)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	(711,923)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (711,923)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (726,186)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(501)	0	0	0	0	0	0	0	0	0	0	(501)	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	1,311	0	0	0	0	0	0	0	0	1,311	5
6	Maintenance	0	0	6,371	7,748	0	0	0	0	0	0	0	14,119	6
7	Other (specify):*	0	0	0	0	760	0	0	0	0	0	0	760	7
8	TOTAL General Services	(501)	0	7,682	7,748	760	0	0	0	0	0	0	15,689	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	(1,960)	0	0	0	0	0	(1,960)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(1,960)	0	0	0	0	0	(1,960)	16
	C. General Administration													
17	Administrative	0	(73,200)	0	104,134	0	0	0	0	0	0	0	30,934	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(397)	377	1,262	0	0	0	0	0	0	0	0	1,242	19
20	Fees, Subscriptions & Promotions	(57,612)	0	832	0	0	0	0	0	0	0	0	(56,780)	20
21	Clerical & General Office Expenses	(147)	(307,250)	57,155	8,834	0	0	0	0	0	0	0	(241,408)	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	222	0	0	0	0	0	0	0	0	222	24
25	Other Admin. Staff Transportation	0	0	1,272	0	0	0	0	0	0	0	0	1,272	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,964	0	0	0	0	0	0	0	0	4,964	26
27	Other (specify):*	(58,634)	0	10,672	0	20,845	0	0	0	0	0	0	(27,117)	27
28	TOTAL General Administration	(116,790)	(380,073)	76,379	112,968	20,845	0	0	0	0	0	0	(286,671)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,291)	(380,073)	84,061	120,716	21,605	(1,960)	0	0	0	0	0	(272,942)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION# 0031823

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	107,870	0	10,776	0	0	0	0	0	0	0	0	118,646	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,842)	380,684	3,155	0	0	0	0	0	0	0	0	378,997	32
33	Real Estate Taxes	0	0	4,024	0	0	0	0	0	0	0	0	4,024	33
34	Rent-Facility & Grounds	0	(960,700)	0	0	0	0	0	0	0	0	0	(960,700)	34
35	Rent-Equipment & Vehicles	0	0	7,275	0	0	0	0	0	0	0	0	7,275	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	103,028	(580,016)	25,230	0	0	0	0	0	0	0	0	(451,758)	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	(1,486)	0	0	0	0	0	(1,486)	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	(1,486)	0	0	0	0	0	(1,486)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,263)	(960,089)	109,291	120,716	21,605	(3,446)	0	0	0	0	0	(726,186)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 BOOKKEEPING SERVICES	\$ 307,250			\$	\$ (307,250)	1
2	V	17 MANAGEMENT FEES	73,200				(73,200)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	960,700				(960,700)	7
8	V	32 INTEREST				380,684	380,684	8
9	V	19 LEGAL & ACCOUNTING				377	377	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,341,150			\$ 381,061	\$ * (960,089)	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		\$ 1,311	\$	1,311	15
16	V	6 REPAIR & MAINT.		" " "		6,371		6,371	16
17	V	19 PROFESSIONAL FEES		" " "		1,262		1,262	17
18	V	20 DUES AND SUBSCRIPTION		" " "		832		832	18
19	V	21 CLERICAL & GENERAL		" " "		57,155		57,155	19
20	V	24 SEMINARS AND TRAVEL		" " "		222		222	20
21	V	25 AUTO EXPENSE		" " "		1,272		1,272	21
22	V	26 INSURANCE		" " "		4,964		4,964	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		10,672		10,672	23
24	V	30 DEPRECIATION		" " "		10,776		10,776	24
25	V	32 INTEREST		" " "		3,155		3,155	25
26	V	33 REAL ESTATE TAXES		" " "		4,024		4,024	26
27	V	35 EQUIPMENT RENTAL		" " "		7,275		7,275	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 109,291	\$ *	109,291	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 7,748	\$ 7,748
16	V	10 DON SALARY - NON OWNER		" " "			
17	V	17 ADMIN. CMP. - M. MAUER		" " "		21,073	21,073
18	V	17 ADMIN. CMP. - M. AARON		" " "		23,977	23,977
19	V	17 ADMIN. CMP. - F. AARON		" " "		10,399	10,399
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "			
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "			
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		14,902	14,902
23	V	17 ADMIN. CMP. - S. LEVY		" " "		20,141	20,141
24	V	17 ADMIN. CMP. - HOWARD ALTER		" " "			
25	V	17 ADMIN. CMP. - NON-OWNER		" " "		13,642	13,642
26	V	21 CLERICAL. CMP. - S. AARON		" " "		8,834	8,834
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 120,716	\$ * 120,716

* 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	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 760	\$ 760	15
16	V	17 EMP. BEN. - DON NON OWNER		" " "				16
17	V	27 EMP. BEN. - M. MAUER		" " "		1,506	1,506	17
18	V	27 EMP. BEN. - M. AARON		" " "		2,379	2,379	18
19	V	27 EMP. BEN. - F. AARON		" " "		7,367	7,367	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "				20
21	V	27 EMP. BEN. - S. KOPLIN		" " "				21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		2,626	2,626	22
23	V	27 EMP. BEN. - S. LEVY		" " "		2,067	2,067	23
24	V	27 EMP. BEN. - H. ALTER		" " "				24
25	V	27 EMP. BEN. - NON-OWNER		" " "		3,100	3,100	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,800	1,800	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 21,605	\$ * 21,605	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	10 MEDICAL SUPPLIES	\$ 17,449	LINCOLN MEDICAL SUPPLIES, INC.		\$ 15,489	\$ (1,960)	15
16	V	39 ANCILLARY EXPENSE	13,232	" " "		11,746	(1,486)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 30,681			\$ 27,235	\$ * (3,446)	39

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

Facility Name & ID Number

WINDMILL NURSING PAVILION

#

0031823

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 21,073	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	23,977	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	10,399	17-7	3
4	" "		ADMINISTRATIVE					SALARY	37,250	17-7	4
5	" "		ADMINISTRATIVE					MGMT FEE	19,200	17-3	5
6	SHARON AARON		CLERICAL					SALARY	8,834	17-7	6
7	DENNIS NEHMER		MAINTENANCE					SALARY	7,748	17-7	7
8	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	14,902	17-7	8
9	" "		ADMINISTRATIVE					SALARY	41,300	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 184,683		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:

01/01/2006

Ending: **2/31/2006**

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

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	5	UTILITIES	TOTAL PATIENT DAYS	408,951	12	\$ 10,593	\$ 50,592	\$ 1,311	1
2	6	REPAIR & MAINT.	"	408,951	12	51,500	50,592	6,371	2
3	19	PROFESSIONAL FEES	"	408,951	12	10,199	50,592	1,262	3
4	20	DUES AND SUBSCRIPTION	"	408,951	12	6,724	50,592	832	4
5	21	CLERICAL & GENERAL	"	408,951	12	461,999	356,210	57,155	5
6	24	SEMINARS AND TRAVEL	"	408,951	12	1,791	50,592	222	6
7	25	AUTO EXPENSE	"	408,951	12	10,284	50,592	1,272	7
8	26	INSURANCE	"	408,951	12	40,124	50,592	4,964	8
9	27	EMP. BEN. - GEN, ADMIN.	"	408,951	12	86,265	50,592	10,672	9
10	30	DEPRECIATION	"	408,951	12	87,103	50,592	10,776	10
11	32	INTEREST	"	408,951	12	25,499	50,592	3,155	11
12	33	REAL ESTATE TAXES	"	408,951	12	32,525	50,592	4,024	12
13	35	EQUIPMENT RENTAL	"	408,951	12	58,806	50,592	7,275	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					\$ 883,412	\$ 356,210	\$ 109,291	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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

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	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	\$ 54,933	\$ 54,933	6	\$ 7,748	1
2	10	DON SALARY - NON OWNER	" "	40	12	74,145	74,145		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	12	170,000	170,000	5	21,073	3
4	17	ADMIN. CMP. - M. AARON	" "	40	12	170,000	170,000	6	23,977	4
5	17	ADMIN. CMP. - F. AARON	" "	47	12	57,500	57,500	9	10,399	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	12	27,199	27,199		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	12	71,067	71,067		0	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	12	105,603	105,603	6	14,902	8
9	17	ADMIN. CMP. - S. LEVY	" "	45	12	162,480	162,480	6	20,141	9
10	17	ADMIN. CMP. - H. ALTER	" "	40	12	12,000	12,000		0	10
11	17	ADMIN. CMP. - NON-OWNER	" "	45	12	96,679	96,679	6	13,642	11
12	21	CLERICAL. CMP. - S. AARON		40	12	71,245	71,245	5	8,834	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,072,851	\$ 1,072,851		\$ 120,716	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 STREET
 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	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	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	12	\$ 5,392	6	\$ 760	1
2	15	EMP.BEN. - DON NON OWNER	" "	40	12	15,214		0	2
3	27	EMP.BEN. - M. MAUER	" "	40	12	12,149	5	1,506	3
4	27	EMP. BEN. - M. AARON	" "	40	12	16,867	6	2,379	4
5	27	EMP. BEN. - F. AARON	" "	47	12	40,734	9	7,367	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	31,524		0	6
7	27	EMP. BEN. - S. KOPLIN	" "	40	12	22,507		0	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	12	18,613	6	2,626	8
9	27	EMP. BEN. - S. LEVY	" "	45	12	16,678	6	2,067	9
10	27	EMP. BEN. - H. ALTER	" "	40	12	1,101		0	10
11	27	EMP. BEN. - NON-OWNER	" "	45	12	21,972	6	3,100	11
12	27	EMP. BEN. - S. AARON	" "	40	12	14,514	5	1,800	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					\$ 217,265	\$	\$ 21,605	25

Facility Name & ID Number **WINDMILL NURSING PAVILION**

0031823

Report Period Beginning:

01/01/2006

Ending: **2/31/2006**

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

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	LINCOLN MEDICAL SUPPLIES				\$	\$		\$	1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						15,489	2
3	39 ANCILLARY EXPENSE	" "						11,746	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				\$	\$		\$ 27,235	25

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	CHASE BANK		X	MORTGAGE	\$55,899.00	10/00	\$ 5,625,000	\$ 4,181,728		8.6500	\$ 380,684	1						
2												2						
3												3						
4												4						
5	RELATED PARTY											5						
Working Capital																		
6	BANK ONE		X	WORKING CAPITAL							13,677	6						
7			X	INSURANCE FINANCING							2,789	7						
8	FORD CREDIT		X	VAN							1,968	8						
9	TOTAL Facility Related				\$55,899.00		\$ 5,625,000	\$ 4,181,728			\$ 399,118	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 5,625,000	\$ 4,181,728			\$ 399,118	15						

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

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

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

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 2005 report.		\$	317,000	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.)		\$	314,321	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,679)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	324,000	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 _____ 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.		\$	321,321	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	269,495	8
	2002	277,542	9
	2003	293,113	10
	2004	305,181	11
	2005	314,321	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
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 2005 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>314,320.78</u>	\$ <u>314,320.78</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>314,320.78</u>	\$ <u>314,320.78</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 X 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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>			\$ <u>408,821</u>	1
2					2
3	TOTALS			\$ 408,821	3

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF 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	\$ 0	30	\$ 106,266	\$ 106,266	\$ 1,806,522	4
5										5
6										6
7										7
8	RELATED PARTY			54,878	1,407		1,568	161	20,906	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1989	6,334	201	31.5	201		3,509	9
10	LEASEHOLD IMPROVEMENT		1990	1,538	49	20	76	27	1,037	10
11	LEASEHOLD IMPROVEMENT		1991	26,695	847	20	1,335	488	17,527	11
12	LEASEHOLD IMPROVEMENT		1992	4,785	152	20	239	87	2,987	12
13	LEASEHOLD IMPROVEMENT		1993	8,024	255	31.5	255		3,510	13
14	LEASEHOLD IMPROVEMENT		1993	36,822	944	39	944		12,613	14
15	LEASEHOLD IMPROVEMENT		1994	38,826	996	39	996		12,145	15
16	LEASEHOLD IMPROVEMENT		1995	21,539	553	39	553		6,449	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996	1,604	41	39	41		443	17
18	ROOF REPAIR		1996	3,800	97	39	97		1,016	18
19	GAZEBO		1996	1,282	33	39	33		342	19
20	ASPHALT REMOVE & REPLACE		1996	2,686	69	39	69		711	20
21	ROOF REPAIR		1996	7,000	180	39	180		1,845	21
22	HOT WATER TANK		1996	12,098	310	39	310		3,138	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997	6,844	175	39	175		1,627	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997	105,092	2,695	39	2,695		35,117	24
25	ROOFING		1997	45,500	1,167	39	1,167		10,846	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997	4,721	121	39	121		1,124	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997	26,497	679	39	679		6,300	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998	3,359	86	39	86		724	28
29	DRAPES & INSTALLATION		1998	5,965	153	39	153		1,279	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998	14,240	365	39	365		3,054	30
31	EXHAUST FAN & INSTALLATION		1998	2,285	59	39	59		484	31
32	ROOF REPAIR		1998	8,750	224	39	224		1,878	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998	22,500	577	39	577		4,848	33
34	ELECTRICAL WORK		1998	5,376	138	39	138		1,153	34
35	COUNTER TOPS		1998	712	18	39	18		150	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	1998	\$ 1,185	\$ 31	39	\$ 31		\$ 243	37
38	NURSES STATION	1999	16,601	426	39	426		3,390	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		874	39
40	FIRE SYSTEM	1999	2,625	67	39	67		532	40
41	FLOOR TILE	1999	10,807	277	39	277		2,205	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		1,900	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		1,700	43
44	AIR CONDITIONING	1999	14,451	371	39	371		2,855	44
45	RAILINGS	1999	3,282	84	39	84		641	45
46	ROOF WORK	1999	4,500	115	39	115		839	46
47	NURSE STATION	2000	7,090	258	27.5	258		1,689	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		1,516	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		1,997	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		615	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		824	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	2,299	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		1,108	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		1,128	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		567	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		1,122	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		470	57
58	CONCRETE PAD	2002	1,662	81	15	111	30	498	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		113	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		558	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		883	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		287	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		266	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		1,009	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		342	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		1,701	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		1,214	67
68	AIR CONDITIONING	2004	664	24	27.5	24		59	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,862,124	\$ 18,859		\$ 126,108	\$ 107,249	\$ 1,998,728	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 3,862,124	\$ 18,859		\$ 126,108	\$ 107,249	\$ 1,998,728	1
2	WATER HEATER, VALVE & PUMPS	2004	6,594	240	27.5	240		590	2
3	FIRE DOORS	2004	769	28	27.5	28		69	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		405	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		561	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		77	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		100	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	48	27.5	48		48	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	54	27.5	54		54	9
10	WALL AIR CONDITIONER	2006	2,835	47	27.5	47		47	10
11	CONCRETE SIDEWALKS	2006	19,403	647	15	647		647	11
12	LANDSCAPING	2006	10,250	342	15	342		342	12
13	FREEZER COMPRESSOR	2006	1,000	16	27.5	16		16	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	108	27.5	108		108	14
15	EXIT SIGNS	2006	1,316	22	27.5	22		22	15
16	REPAIR FENCE	2006	2,000	66	15	66		66	16
17	FIRE DOORS	2006	1,058	18	27.5	18		18	17
18	CONCRETE WORK	2006	2,200	37	27.5	37		37	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	TOTAL (lines 1 thru 33)		\$ 3,943,719	\$ 21,316		\$ 128,565	\$ 107,249	\$ 2,001,935	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 436,045	\$ 29,421	\$ 40,692	\$ 11,271	10 YRS	\$ 261,121	71
72	Current Year Purchases	75,095	15,019	3,755	(11,264)	10YRS	3,755	72
73	Fully Depreciated Assets	228,364			0		228,364	73
74	RELATED PARTY	63,235	9,368	5,502	(3,866)			74
75	TOTALS	\$ 802,739	\$ 53,808	\$ 49,949	\$ (3,859)		\$ 493,240	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		2004 FORD E 450		\$ 43,085	\$ 4,137	\$ 8,617	\$ 4,480	5	\$ 21,543	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 43,085	\$ 4,137	\$ 8,617	\$ 4,480		\$ 21,543	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)	\$ 5,198,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,261	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,131	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 107,870	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,516,718	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 3,971 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		\$	\$	21

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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	39-3	hrs	\$		\$ 224,663	\$		\$ 224,663	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,651			9,651	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			232,893			232,893	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				108,506		108,506	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, XRAY Other (specify):						25,132		25,132	13
14	TOTAL			\$		\$ 467,207	\$ 133,638		\$ 600,845	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.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 116,707	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,611,523		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,213		6
7	Other Prepaid Expenses	6,020		7
8	Accounts Receivable (owners or related parties)	191,686		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,999,149	\$ 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	700,852		15
16	Equipment, at Historical Cost	782,589		16
17	Accumulated Depreciation (book methods)	(842,501)		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): <u>HOUSE, DEPOSIT</u>	91,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 731,940	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,731,089	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 347,250	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	575,770		29
30	Accrued Salaries Payable	235,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,064		31
32	Accrued Real Estate Taxes(Sch.IX-B)	324,000		32
33	Accrued Interest Payable	1,381		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,501,333	\$ 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
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,501,333	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,229,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,731,089	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,050,839	1
2	Restatements (describe):		2
3	INVESTMENT IN HOUSE	90,000	3
4	EXPENSE RELATING TO HOUSE	(12,405)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,128,434	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	101,322	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)	\$ 101,322	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)	\$ 1,229,756	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,589,786	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,589,786	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,627	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 363,627	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,842	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,842	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	25,000	27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,983,255	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	966,538	31
32	Health Care	2,338,003	32
33	General Administration	1,521,511	33
	B. Capital Expense		
34	Ownership	1,372,911	34
	C. Ancillary Expense		
35	Special Cost Centers	600,845	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)*	\$ 6,881,933	40
41	Income before Income Taxes (line 30 minus line 40)**	101,322	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 101,322	43

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

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

TAX RETURN PREPARED ON CASH BASIS

*** 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: 01/01/2006

Ending: 12/31/2006

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	1,845	2,053	\$ 78,999	\$ 38.48	1
2	Assistant Director of Nursing	3,109	3,559	83,360	23.42	2
3	Registered Nurses	3,337	3,498	99,314	28.39	3
4	Licensed Practical Nurses	37,340	40,471	868,966	21.47	4
5	CNAs & Orderlies	85,596	91,937	956,279	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,111	26,293	12.46	9
10	Activity Assistants	8,260	8,837	72,602	8.22	10
11	Social Service Workers	2,800	3,203	40,904	12.77	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,206	38,340	17.38	13
14	Head Cook	1,984	2,144	26,217	12.23	14
15	Cook Helpers/Assistants	15,680	17,292	155,306	8.98	15
16	Dishwashers					16
17	Maintenance Workers	3,693	4,013	60,025	14.96	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,891	2,134	82,559	38.69	20
21	Assistant Administrator	2,300	2,539	54,987	21.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,291	8,957	180,596	20.16	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	1,715	2,028	23,502	11.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,739	196,982	\$ 2,848,249 *	\$ 14.46	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	\$ 8,880	1-3	35
36	Medical Director	600	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	4,946	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	155	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	26	10a-3	43
44	Activity Consultant	38	11-3	44
45	Social Service Consultant	20	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	58	\$ 17,555	49

C. CONTRACT NURSES

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

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	ADMINISTRATOR		\$ 82,559	Workers' Compensation Insurance	\$ 85,285	IDPH License Fee	\$ 995	
JOYCE MCGEE	ASST ADMIN		54,987	Unemployment Compensation Insurance	46,105	Advertising: Employee Recruitment	1,918	
				FICA Taxes	215,231	Health Care Worker Background Check	2,010	
				Employee Health Insurance	84,678	(Indicate # of checks performed)		
				Employee Meals	24,090	Patient Background Checks	1,780	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,480	
				EMPLOYEE BENEFITS - OTHER	9,527	MARKETING/ADV/PROMO	54,132	
						LICENSES/DUES/SUBSCRIPTIONS	8,165	
						MGMT CO ALLOC	832	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,546			TRUST/FRANCHISE/CONTRIB/ETC	(3,480)	
B. Administrative - Other						Less: Public Relations Expense	(0)	
Description			Amount			Non-allowable advertising	(54,132)	
FRED AARON			\$ 19,200			Yellow page advertising	(0)	
MANAGEMENT FEES			54,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 73,200	TOTAL (agree to Schedule V, line 22, col.8)	\$ 464,916	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,700	
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	\$
							In-State Travel	0
							Seminar Expense	0
							MGMT CO ALLOC	222
							Entertainment Expense	()
SEE SCHEDULE ATTACHED			69,806				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 69,806	TOTAL		\$	TOTAL	\$ 222

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. ICLTC \$8,100
- (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. \$ 83 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 _____ 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. \$ 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, 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. \$ 24,090 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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