



Facility Name & ID Number WINDMILL NURSING PAVILION

# 0031823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	1,212	435	3,591	5,238	8
9	SNF/PED					9
10	ICF	38,934	2,019	2,919	43,872	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,146	2,454	6,510	49,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.70%

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 01/02/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/02/1987 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 3,529

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	229,423	22,688	8,880	260,991		260,991		260,991		1
2	Food Purchase		208,774		208,774	(26,937)	181,837	(809)	181,028		2
3	Housekeeping		24,306	146,422	170,728		170,728		170,728		3
4	Laundry		15,031	81,629	96,660		96,660		96,660		4
5	Heat and Other Utilities			145,109	145,109		145,109	1,225	146,334		5
6	Maintenance	60,182	40,552	14,425	115,159		115,159	17,996	133,155		6
7	Other (specify):*			11,978	11,978		11,978	817	12,795		7
8	<b>TOTAL General Services</b>	<b>289,605</b>	<b>311,351</b>	<b>408,443</b>	<b>1,009,399</b>	<b>(26,937)</b>	<b>982,462</b>	<b>19,229</b>	<b>1,001,691</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	2,163,630	92,440	4,914	2,260,984		2,260,984	(1,168)	2,259,816		10
10a	Therapy		2,304		2,304		2,304		2,304		10a
11	Activities	105,016	10,092	1,688	116,796		116,796		116,796		11
12	Social Services	35,559		715	36,274		36,274		36,274		12
13	CNA Training										13
14	Program Transportation			715	715		715		715		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,304,205</b>	<b>104,836</b>	<b>8,632</b>	<b>2,417,673</b>		<b>2,417,673</b>	<b>(1,168)</b>	<b>2,416,505</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	149,553		53,200	202,753		202,753	65,584	268,337		17
18	Directors Fees										18
19	Professional Services			64,416	64,416		64,416	3,027	67,443		19
20	Dues, Fees, Subscriptions & Promotions			72,635	72,635		72,635	(53,792)	18,843		20
21	Clerical & General Office Expenses	158,546	14,487	429,172	602,205		602,205	(327,992)	274,213		21
22	Employee Benefits & Payroll Taxes			458,987	458,987	26,937	485,924		485,924		22
23	Inservice Training & Education			2,128	2,128		2,128		2,128		23
24	Travel and Seminar							334	334		24
25	Other Admin. Staff Transportation			610	610		610	1,782	2,392		25
26	Insurance-Prop.Liab.Malpractice			117,832	117,832		117,832	2,515	120,347		26
27	Other (specify):*							34,874	34,874		27
28	<b>TOTAL General Administration</b>	<b>308,099</b>	<b>14,487</b>	<b>1,198,980</b>	<b>1,521,566</b>	<b>26,937</b>	<b>1,548,503</b>	<b>(273,668)</b>	<b>1,274,835</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,901,909</b>	<b>430,674</b>	<b>1,616,055</b>	<b>4,948,638</b>		<b>4,948,638</b>	<b>(255,607)</b>	<b>4,693,031</b>		<b>29</b>

\*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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,880
	REPAIRS & MAINTENANCE	0
		0
		8,880
3	<b>HOUSEKEEPING</b>	
	CONTRACTED HOUSEKEEPING SERVICE	146,422
		0
		146,422
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	888
	CONTRACTED LAUNDRY SERVICES	80,741
		0
		81,629
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	42,390
	ELECTRICITY	79,216
	WATER	22,829
	CABLE TV - LOBBY	674
		0
		145,109
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	7,585
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,965
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,875
	FIRE SERVICE	0
		0
		0
		0
		0
		14,425
7	<b>OTHER</b>	
	SCAVENGER	11,978
	SECURITY SERVICE	0
		0
		0
		11,978
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	600
		600

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	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	4,914
	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
		4,914
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,688
		0
		1,688
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	715
		0
		715
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	715
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	53,200
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,520
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	58,896
		0
		64,416
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	52,820
	EMPLOYEE WANT ADS XIX F	6,220
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,032
	LICENSES & PERMITS XIX F	2,181
	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	1,912
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	470
	PATIENT BACKGROUND CHECKS XIX F	0
		72,635
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	197
	EQUIPMENT REPAIR & MAINTENANCE	14,146
	OUTSIDE CLERICAL SERVICES	399,700
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,129
	MESSENGER SERVICE	0
		0
		429,172

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	219,736
	UNEMPLOYMENT COMPENSATION XIX D	41,338
	WORKERS COMPENSATION INSURANC XIX D	94,641
	HOSPITALIZATION INSURANCE XIX D	87,804
	EMPLOYEE BENEFITS - OTHER XIX D	15,468
	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
		458,987
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	2,128
		2,128
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	610
		610
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	117,832
		117,832
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,616,055

**WINDMILL NURSING PAVILION  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	208,774
LESS SALES TAX	<u>(809)</u>
NET FOOD	207,965
TOTAL PATIENT CENSUS	49,110
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	147,330
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	21,900
PATIENT MEALS	147,330
ADD EMPLOYEE MEALS	<u>21,900</u>
TOTAL MEALS/YEAR	169,230
NET FOOD	207,965
DIVIDE TOTAL MEALS/YEAR	<u>169,230</u>
COST PER MEAL	1.23
TIME EMPLOYEE MEALS	<u>21,900</u>
EMPLOYEE MEAL RECLASSIFICATION	<b><u>26,937</u></b>
	=====

**V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			75,184	75,184		75,184	118,943	194,127		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			47,950	47,950		47,950	350,004	397,954		32
33	Real Estate Taxes			353,205	353,205		353,205	4,329	357,534		33
34	Rent-Facility & Grounds			958,200	958,200		958,200	(958,200)			34
35	Rent-Equipment & Vehicles			4,103	4,103		4,103	9,318	13,421		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,438,642	1,438,642		1,438,642	(475,606)	963,036		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		104,476	863,312	967,788		967,788	(384)	967,404		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,125	82,125		82,125		82,125		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		104,476	945,437	1,049,913		1,049,913	(384)	1,049,529		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,901,909	535,150	4,000,134	7,437,193		7,437,193	(731,597)	6,705,596		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	115,732	30		9
10	Interest and Other Investment Income	(7,853)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(809)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,912)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(52,820)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(808)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 51,530		\$	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)	(783,127)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (783,127)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (731,597)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	NON ALLOWABLE FEGAL FEES	\$ (808)	19
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	<b>Total</b>	(808)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(809)	0	0	0	0	0	0	0	0	0	0	(809)	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	1,225	0	0	0	0	0	0	0	0	1,225	5
6	Maintenance	0	0	9,599	8,397	0	0	0	0	0	0	0	17,996	6
7	Other (specify):*	0	0	0	0	817	0	0	0	0	0	0	817	7
8	<b>TOTAL General Services</b>	<b>(809)</b>	<b>0</b>	<b>10,824</b>	<b>8,397</b>	<b>817</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>19,229</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,168)	0	0	0	0	0	(1,168)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,168)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,168)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(53,200)	0	118,784	0	0	0	0	0	0	0	65,584	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(808)	368	3,467	0	0	0	0	0	0	0	0	3,027	19
20	Fees, Subscriptions & Promotions	(54,732)	0	940	0	0	0	0	0	0	0	0	(53,792)	20
21	Clerical & General Office Expenses	0	(399,700)	62,509	9,199	0	0	0	0	0	0	0	(327,992)	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	334	0	0	0	0	0	0	0	0	334	24
25	Other Admin. Staff Transportation	0	0	1,782	0	0	0	0	0	0	0	0	1,782	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,515	0	0	0	0	0	0	0	0	2,515	26
27	Other (specify):*	0	0	12,802	0	22,072	0	0	0	0	0	0	34,874	27
28	<b>TOTAL General Administration</b>	<b>(55,540)</b>	<b>(452,532)</b>	<b>84,349</b>	<b>127,983</b>	<b>22,072</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(273,668)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(56,349)</b>	<b>(452,532)</b>	<b>95,173</b>	<b>136,380</b>	<b>22,889</b>	<b>(1,168)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(255,607)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	115,732	0	3,211	0	0	0	0	0	0	0	0	118,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,853)	354,182	3,675	0	0	0	0	0	0	0	0	350,004	32
33	Real Estate Taxes	0	0	4,329	0	0	0	0	0	0	0	0	4,329	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	9,318	0	0	0	0	0	0	0	0	9,318	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>107,879</b>	<b>(604,018)</b>	<b>20,533</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(475,606)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(384)	0	0	0	0	0	(384)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(384)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(384)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>51,530</b>	<b>(1,056,550)</b>	<b>115,706</b>	<b>136,380</b>	<b>22,889</b>	<b>(1,552)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(731,597)</b>	<b>45</b>

**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	21 BOOKKEEPING SERVICES	\$ 399,700	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (399,700)	1
2	V	17 MANAGEMENT FEES	53,200	" " "			(53,200)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	958,200	16000 S. WABASH			(958,200)	7
8	V	32 INTEREST		" " "		354,182	354,182	8
9	V	19 LEGAL & ACCOUNTING		" " "		368	368	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,411,100			\$ 354,550	\$ * (1,056,550)	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%	\$ 1,225	\$	1,225	15
16	V	6 REPAIR & MAINT.		" " "		9,599		9,599	16
17	V	19 PROFESSIONAL FEES		" " "		3,467		3,467	17
18	V	20 DUES AND SUBSCRIPTION		" " "		940		940	18
19	V	21 CLERICAL & GENERAL		" " "		62,509		62,509	19
20	V	24 SEMINARS AND TRAVEL		" " "		334		334	20
21	V	25 AUTO EXPENSE		" " "		1,782		1,782	21
22	V	26 INSURANCE		" " "		2,515		2,515	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		12,802		12,802	23
24	V	30 DEPRECIATION		" " "		3,211		3,211	24
25	V	32 INTEREST		" " "		3,675		3,675	25
26	V	33 REAL ESTATE TAXES		" " "		4,329		4,329	26
27	V	35 EQUIPMENT RENTAL		" " "		9,318		9,318	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		\$			\$ 115,706	\$ *	115,706	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	100.00%	\$ 8,397	\$	8,397	15
16	V	10 DON SALARY - NON OWNER		" " "					16
17	V	17 ADMIN. CMP. - M. MAUER		" " "		22,790		22,790	17
18	V	17 ADMIN. CMP. - M. AARON		" " "		26,056		26,056	18
19	V	17 ADMIN. CMP. - F. AARON		" " "		19,050		19,050	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "					20
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "					21
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		15,300		15,300	22
23	V	17 ADMIN. CMP. - HOWARD ALTER		" " "					23
24	V	17 ADMIN. CMP. - NON-OWNER		" " "		14,130		14,130	24
25	V	17 ADMIN. CMP. - CFO NON-OWNER		" " "		21,458		21,458	25
26	V	21 CLERICAL. CMP. - S. AARON		" " "		9,199		9,199	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		\$			\$ 136,380	\$ *	136,380	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	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 817	\$	817	15
16	V	17 EMP. BEN. - DON NON OWNER		" " "					16
17	V	27 EMP. BEN. - M. MAUER		" " "		1,662		1,662	17
18	V	27 EMP. BEN. - M. AARON		" " "		2,187		2,187	18
19	V	27 EMP. BEN. - F. AARON		" " "		8,779		8,779	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "					20
21	V	27 EMP. BEN. - S. KOPLIN		" " "					21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		1,275		1,275	22
23	V	27 EMP. BEN. - H. ALTER		" " "					23
24	V	27 EMP. BEN. - NON-OWNER		" " "		3,460		3,460	24
25	V	27 EMP. BEN. - CFO NON-OWNER		" " "		2,774		2,774	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,935		1,935	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	<b>Total</b>		\$			\$ 22,889	\$ *	22,889	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	\$ 40,065	LINCOLN MEDICAL SUPPLIES, INC.		\$ 38,897	\$ (1,168)
16	V	39 ANCILLARY EXPENSE	13,156	" " "		12,772	(384)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 53,221			\$ 51,669	\$ * (1,552)

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

Facility Name &amp; ID Number

WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	\$ 22,790	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	26,056	2
3	FRED AARON		ADMINISTRATIVE					SALARY	19,050	3
4	" "		ADMINISTRATIVE					SALARY	22,750	4
5	SHARON AARON		CLERICAL					SALARY	9,199	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	8,397	6
7	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	15,300	7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 123,542	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:

**01/01/2007**

Ending: **2/31/2007**

**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	388,610	11	\$ 9,690	\$ 49,110	\$ 1,225	1
2	6	REPAIR & MAINT.	"	388,610	11	75,959	49,110	9,599	2
3	19	PROFESSIONAL FEES	"	388,610	11	27,437	49,110	3,467	3
4	20	DUES AND SUBSCRIPTION	"	388,610	11	7,442	49,110	940	4
5	21	CLERICAL & GENERAL	"	388,610	11	494,636	380,513	62,509	5
6	24	SEMINARS AND TRAVEL	"	388,610	11	2,640	49,110	334	6
7	25	AUTO EXPENSE	"	388,610	11	14,104	49,110	1,782	7
8	26	INSURANCE	"	388,610	11	19,903	49,110	2,515	8
9	27	EMP. BEN. - GEN, ADMIN.	"	388,610	11	101,305	49,110	12,802	9
10	30	DEPRECIATION	"	388,610	11	25,409	49,110	3,211	10
11	32	INTEREST	"	388,610	11	29,080	49,110	3,675	11
12	33	REAL ESTATE TAXES	"	388,610	11	34,252	49,110	4,329	12
13	35	EQUIPMENT RENTAL	"	388,610	11	73,733	49,110	9,318	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					\$ 915,590	\$ 380,513	\$ 115,706	25

Facility Name & ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 58,010	\$ 58,010	6	\$ 8,397	1
2	10	DON SALARY - NON OWNER	" "	40	11	73,306	73,306			2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	180,000	180,000	5	22,790	3
4	17	ADMIN. CMP. - M. AARON	" "	40	11	180,000	180,000	6	26,056	4
5	17	ADMIN. CMP. - F. AARON	" "	45	11	95,250	95,250	9	19,050	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	11	37,505	37,505			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	30	11	71,549	71,549			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	50	11	105,666	105,666	7	15,300	8
9	17	ADMIN. CMP. - S. LEVY	" "	40	11	12,000	12,000			9
10	17	ADMIN. CMP. - H. ALTER	" "	45	11	97,823	97,823	7	14,130	10
11	17	ADMIN. CMP. - NON-OWNER	" "	45	11	169,480	169,480	6	21,458	11
12	21	CLERICAL. CMP. - S. AARON		40	11	72,716	72,716	5	9,199	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					\$ 1,153,305	\$ 1,153,305		\$ 136,380	25

Facility Name & ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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	11	\$ 5,643	6	\$ 817	1
2	15	EMP.BEN. - DON NON OWNER	" "	40	11	19,251			2
3	27	EMP.BEN. - M. MAUER	" "	40	11	13,131	5	1,662	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,105	6	2,187	4
5	27	EMP. BEN. - F. AARON	" "	45	11	43,896	9	8,779	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	34,284			6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	25,887			7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	8,807	7	1,275	8
9	27	EMP. BEN. - S. LEVY	" "	40	11	1,120			9
10	27	EMP. BEN. - H. ALTER	" "	45	11	23,953	7	3,460	10
11	27	EMP. BEN. - NON-OWNER	" "	45	11	21,910	6	2,774	11
12	27	EMP. BEN. - S. AARON	" "	40	11	15,300	5	1,935	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					\$ 228,287	\$	\$ 22,889	25

Facility Name & ID Number WINDMILL NURSING PAVILION

# 0031823 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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						38,897	2
3	39 ANCILLARY EXPENSE	" "						12,772	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				\$	\$		\$	51,669

Facility Name & ID Number

WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	CHASE BANK		X	MORTGAGE	\$55,889.00	10/00	\$ 5,625,000	\$ 3,865,124		8.6500	\$ 354,182	1						
2												2						
3												3						
4												4						
5	RELATED PARTY										3,675	5						
<b>Working Capital</b>																		
6	CHASE BANK		X	LINE OF CREDIT	INTEREST	9/07	600,000	350,000	9/08	7.7500	44,220	6						
7	FORD CREDIT		X	VAN				15,462			1,276	7						
8			X	INSURANCE FINANCING							2,454	8						
9	TOTAL Facility Related				\$55,889.00		\$ 6,225,000	\$ 4,230,586			\$ 405,807	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 6,225,000	\$ 4,230,586			\$ 405,807	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 2006 report.	\$	<b>324,000</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>334,205</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>10,205</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>343,000</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>353,205</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>277,542</b>	<b>8</b>
	2003	<b>293,113</b>	<b>9</b>
	2004	<b>305,181</b>	<b>10</b>
	2005	<b>314,321</b>	<b>11</b>
	2006	<b>334,205</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>332,581.53</u>	\$ <u>332,581.53</u>
2. <u>30-30-223-039-0000</u>	<u>NURSING HOME</u>	\$ <u>1,623.10</u>	\$ <u>1,623.10</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>334,204.63</u>	\$ <u>334,204.63</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

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.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: NURSING HOME, Row 2: (blank), Row 3: TOTALS

Facility Name &amp; ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$	30	\$ 106,266	\$ 106,266	\$ 1,912,788	4
5										5
6										6
7										7
8	RELATED PARTY			56,059	1,437	35	1,602	165	22,957	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1989	6,334	201	31.5	201		3,710	9
10	LEASEHOLD IMPROVEMENT		1990	1,538	49	20	76	27	1,113	10
11	LEASEHOLD IMPROVEMENT		1991	26,695	847	20	1,335	488	18,862	11
12	LEASEHOLD IMPROVEMENT		1992	4,785	152	20	239	87	3,226	12
13	LEASEHOLD IMPROVEMENT		1993	8,024	255	31.5	255		3,765	13
14	LEASEHOLD IMPROVEMENT		1993	36,822	944	39	944		13,557	14
15	LEASEHOLD IMPROVEMENT		1994	38,826	996	39	996		13,141	15
16	LEASEHOLD IMPROVEMENT		1995	21,539	553	39	553		7,002	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996	1,604	41	39	41		484	17
18	ROOF REPAIR		1996	3,800	97	39	97		1,113	18
19	GAZEBO		1996	1,282	33	39	33		375	19
20	ASPHALT REMOVE & REPLACE		1996	2,686	69	39	69		780	20
21	ROOF REPAIR		1996	7,000	180	39	180		2,025	21
22	HOT WATER TANK		1996	12,098	310	39	310		3,448	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997	6,844	175	39	175		1,802	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997	105,092	2,695	39	2,695		37,812	24
25	ROOFING		1997	45,500	1,167	39	1,167		12,013	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997	4,721	121	39	121		1,245	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997	26,497	679	39	679		6,979	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998	3,359	86	39	86		810	28
29	DRAPES & INSTALLATION		1998	5,965	153	39	153		1,432	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998	14,240	365	39	365		3,419	30
31	EXHAUST FAN & INSTALLATION		1998	2,285	59	39	59		543	31
32	ROOF REPAIR		1998	8,750	224	39	224		2,102	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998	22,500	577	39	577		5,425	33
34	ELECTRICAL WORK		1998	5,376	138	39	138		1,291	34
35	COUNTER TOPS		1998	712	18	39	18		168	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 &amp; ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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		\$ 274	37
38	NURSES STATION	1999	16,601	426	39	426		3,816	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		996	39
40	FIRE SYSTEM	1999	2,625	67	39	67		599	40
41	FLOOR TILE	1999	10,807	277	39	277		3,482	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		2,146	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		1,927	43
44	AIR CONDITIONING	1999	14,451	371	39	371		3,226	44
45	RAILINGS	1999	3,282	84	39	84		725	45
46	ROOF WORK	1999	4,500	115	39	115		954	46
47	NURSE STATION	2000	7,090	258	27.5	258		1,947	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		1,747	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		2,301	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		709	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		950	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	2,717	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		1,314	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		1,337	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		673	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		1,330	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		558	57
58	CONCRETE PAD	2002	1,662	72	15	111	39	609	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		139	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		693	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		1,085	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		370	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		343	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		1,300	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		481	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		2,393	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		1,708	67
68	AIR CONDITIONING	2004	664	24	27.5	24		83	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,863,305	\$ 18,880		\$ 126,142	\$ 107,262	\$ 2,126,319	70

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

Facility Name &amp; ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,863,305	\$ 18,880		\$ 126,142	\$ 107,262	\$ 2,126,319	1
2	WATER HEATER, VALVE & PUMPS	2004	6,594	240	27.5	240		830	2
3	FIRE DOORS	2004	769	28	27.5	28		97	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		683	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		945	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		130	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		169	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		152	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		172	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		150	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		1,941	11
12	LANDSCAPING	2006	10,250	683	15	683		1,025	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		52	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		344	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		70	15
16	REPAIR FENCE	2006	2,000	133	15	133		199	16
17	FIRE DOORS	2006	1,058	39	27.5	39		57	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		117	18
19	GAZEBO	2007	4,671	156	15	156		156	19
20	DISH NETWORK CABLING	2007	19,000	317	27.5	317		317	20
21	WALL AIR CONDITIONER	2007	3,374	56	27.5	56		56	21
22	SECURITY DOORS	2007	4,837	81	27.5	81		81	22
23	PARKING LOT PAVING	2007	4,492	75	27.5	75		75	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	38	27.5	38		38	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	64	27.5	64		64	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,987,399	\$ 23,593		\$ 130,855	\$ 107,262	\$ 2,134,239	34

\*\*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:

01/01/2007

Ending:

12/31/2007

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	\$ 501,971	\$ 41,726	\$ 46,646	\$ 4,920	10 YRS	\$ 302,352	71
72	Current Year Purchases	44,104	8,820	2,205	(6,615)	10 YRS	2,205	72
73	Fully Depreciated Assets	237,534					237,534	73
74	RELATED PARTY	108,164	423	2,869	2,446		99,165	74
75	TOTALS	\$ 891,773	\$ 50,969	\$ 51,720	\$ 751		\$ 641,256	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	FACILITY	2004 FORD E 450	2004	\$ 43,085	\$ 2,482	\$ 8,617	\$ 6,135	5	\$ 30,160	76
77	RELATED PARTY			21,791	1,351	2,935	1,584		14,453	77
78										78
79										79
80	TOTALS			\$ 64,876	\$ 3,833	\$ 11,552	\$ 7,719		\$ 44,613	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)	\$ 5,352,869	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,395	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,127	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 115,732	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,820,108	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	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: \$ 4,103 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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

**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	\$		\$ 361,281	\$		\$ 361,281	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,605			15,605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			486,426			486,426	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				82,031		82,031	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED SUPPLIES, LAB,RADIOLOGY Other (specify): <b>RENTALS</b>						22,445		22,445	13
14	<b>TOTAL</b>			\$		\$ 863,312	\$ 104,476		\$ 967,788	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 398,271	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 201,000 )	1,006,467		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,105		6
7	Other Prepaid Expenses	3,573		7
8	Accounts Receivable (owners or related parties)	191,166		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,663,582	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	743,351		15
16	Equipment, at Historical Cost	826,692		16
17	Accumulated Depreciation (book methods)	(917,685)		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 (spec DEPOSIT	2,700		22
23	Other(specify): INVESTMENT	92,200		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 747,258	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,410,840	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 450,396	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	365,462		29
30	Accrued Salaries Payable	243,986		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,552		31
32	Accrued Real Estate Taxes(Sch.IX-B)	343,000		32
33	Accrued Interest Payable	1,531		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,419,927	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,419,927	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 990,913	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,410,840	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,229,759</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,229,759</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(238,846)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(238,846)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>990,913</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,305,714	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,305,714	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	884,780	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 884,780	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7,853	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,853	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,198,347	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,009,399	31
32	Health Care	2,417,673	32
33	General Administration	1,521,566	33
	<b>B. Capital Expense</b>		
34	Ownership	1,438,642	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	967,788	35
36	Provider Participation Fee	82,125	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,437,193	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(238,846)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (238,846)	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: 01/01/2007

Ending: 12/31/2007

**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	1,819	2,071	\$ 82,691	\$ 39.93	1
2	Assistant Director of Nursing	3,441	3,756	98,282	26.17	2
3	Registered Nurses	5,202	5,378	152,933	28.44	3
4	Licensed Practical Nurses	34,075	37,161	839,730	22.60	4
5	CNAs & Orderlies	83,097	89,433	966,289	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,877	2,078	27,318	13.15	9
10	Activity Assistants	8,494	9,151	77,698	8.49	10
11	Social Service Workers	2,463	2,805	35,559	12.68	11
12	Dietician	1,893	2,118	38,816	18.33	12
13	Food Service Supervisor	1,953	2,141	26,996	12.61	13
14	Head Cook	15,561	17,311	163,611	9.45	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,517	3,963	60,182	15.19	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,973	2,212	87,047	39.35	20
21	Assistant Administrator	2,520	2,761	62,506	22.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,037	9,036	158,546	17.55	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	1,717	1,921	23,705	12.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,639	193,296	\$ 2,901,909 *	\$ 15.01	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,880	1-3	35
36	Medical Director	O	600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,914	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,688	11-3	44
45	Social Service Consultant	E	715	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,797		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		\$ 87,047	Workers' Compensation Insurance	\$ 94,641	IDPH License Fee	\$ 995	
JOYCE MCGEE	ASST ADMIN		62,506	Unemployment Compensation Insurance	41,338	Advertising: Employee Recruitment	6,220	
				FICA Taxes	219,736	Health Care Worker Background Check	470	
				Employee Health Insurance	87,804	(Indicate # of checks performed _____)		
				Employee Meals	26,937	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,912	
				EMPLOYEE BENEFITS - OTHER	15,468	MARKETING/ADV/PROMO	52,820	
						LICENSES/DUES/SUBSCRIPTIONS	10,218	
						MGMT CO ALLOC	940	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 149,553			TRUST/FRANCHISE/CONTRIB/ETC	(1,912)	
(List each licensed administrator separately.)						Less: Public Relations Expense	( 0 )	
						Non-allowable advertising	(52,820)	
						Yellow page advertising	( 0 )	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,843	
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
MANAGEMENT FEE			\$ 53,200				Out-of-State Travel	\$
							In-State Travel	
								0
							RELATED PARTY	334
							Seminar Expense	
								0
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 53,200	TOTAL		\$	TOTAL	\$ 334
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			64,416					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 64,416					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number WINDMILL NURSING PAVILION

# 0031823

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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 IAHC \$1,800
- (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. \$ 384 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. \$ 26,937 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 \$5,000, 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