

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	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	656	260	3,123	4,039	8
9	SNF/PED					9
10	ICF	39,129	1,679	3,397	44,205	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,785	1,939	6,520	48,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.88%

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 01/02/0987

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 3,123

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **WINDMILL NURSING PAVILION** # **0031823** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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
	A. General Services										
1	Dietary	241,067	15,750	8,880	265,697		265,697		265,697		1
2	Food Purchase		233,420		233,420		233,420	(758)	232,662		2
3	Housekeeping		25,734	151,830	177,564		177,564		177,564		3
4	Laundry		16,436	86,773	103,209		103,209		103,209		4
5	Heat and Other Utilities			161,520	161,520		161,520	1,602	163,122		5
6	Maintenance	78,982	50,465	20,480	149,927		149,927	17,486	167,413		6
7	Other (specify):*			14,828	14,828		14,828	848	15,676		7
8	TOTAL General Services	320,049	341,805	444,311	1,106,165		1,106,165	19,178	1,125,343		8
	B. Health Care and Programs										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	2,170,649	120,947	5,082	2,296,678		2,296,678	(5,189)	2,291,489		10
10a	Therapy	269,253	60,726		329,979		329,979		329,979		10a
11	Activities	106,974	10,791	1,776	119,541		119,541		119,541		11
12	Social Services	43,722		2,558	46,280		46,280		46,280		12
13	CNA Training										13
14	Program Transportation			288	288		288		288		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,590,598	192,464	10,304	2,793,366		2,793,366	(5,189)	2,788,177		16
	C. General Administration										
17	Administrative	156,984		46,200	203,184		203,184	104,003	307,187		17
18	Directors Fees										18
19	Professional Services			94,479	94,479		94,479	3,278	97,757		19
20	Dues, Fees, Subscriptions & Promotions			106,205	106,205		106,205	(73,723)	32,482		20
21	Clerical & General Office Expenses	145,860	21,396	482,213	649,469		649,469	(379,903)	269,566		21
22	Employee Benefits & Payroll Taxes			505,724	505,724		505,724		505,724		22
23	Inservice Training & Education			3,626	3,626		3,626		3,626		23
24	Travel and Seminar							219	219		24
25	Other Admin. Staff Transportation			330	330		330	2,956	3,286		25
26	Insurance-Prop.Liab.Malpractice			175,358	175,358		175,358	1,083	176,441		26
27	Other (specify):*			69,171	69,171		69,171	(32,620)	36,551		27
28	TOTAL General Administration	302,844	21,396	1,483,306	1,807,546		1,807,546	(374,707)	1,432,839		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,213,491	555,665	1,937,921	5,707,077		5,707,077	(360,718)	5,346,359		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	0
		0
		8,880
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICE	151,830
		0
		151,830
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,472
	CONTRACTED LAUNDRY SERVICE	84,301
		86,773
5	HEAT & OTHER UTILITIES	
	GAS HEAT	54,065
	ELECTRICITY	86,559
	WATER	19,920
	CABLE TV - LOBBY	976
		0
		161,520
6	MAINTENANCE	
	GROUNDS MAINTENANCE	12,600
	PAINTING & DECORATING	458
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,847
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	0
		0
		0
		0
		0
		20,480
7	OTHER	
	SCAVENGER	14,828
	SECURITY SERVICE	0
		0
		0
		14,828
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	5,082
	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
		5,082
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	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,776
		0
		1,776
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,558
		0
		2,558
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	288
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	46,200
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,773
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	88,706
		0
		94,479
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	67,305
	EMPLOYEE WANT ADS XIX F	19,166
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,092
	LICENSES & PERMITS XIX F	2,899
	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	7,093
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	1,650
		106,205
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	15,927
	OUTSIDE CLERICAL SERVICES	445,000
	PENALTIES / OVERDRAFT CHARGES VI 18	8,126
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,160
	MESSENGER SERVICE	0
		0
		482,213

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	243,920
	UNEMPLOYMENT COMPENSATION XIX D	26,340
	WORKERS COMPENSATION INSURANC XIX D	126,208
	HOSPITALIZATION INSURANCE XIX D	94,088
	EMPLOYEE BENEFITS - OTHER XIX D	15,168
	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
		505,724
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,626
		3,626
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	330
		330
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	175,358
		175,358
27	OTHER	
	BAD DEBTS VI 24	69,171
		69,171

GRAND TOTAL COLUMN 3 OTHER

1,937,921

**WINDMILL NURSING PAVILION
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	233,420
LESS SALES TAX	<u>(758)</u>
NET FOOD	232,662

TOTAL PATIENT CENSUS	48,244
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	144,732

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	144,732
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	144,732

NET FOOD	232,662
DIVIDE TOTAL MEALS/YEAR	<u>144,732</u>

COST PER MEAL	1.61
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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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			83,910	83,910		83,910	113,949	197,859		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			23,863	23,863		23,863	326,985	350,848		32
33	Real Estate Taxes			332,384	332,384		332,384	5,476	337,860		33
34	Rent-Facility & Grounds			958,200	958,200		958,200	(958,200)			34
35	Rent-Equipment & Vehicles			11,205	11,205		11,205	9,296	20,501		35
36	Other (specify):*										36
37	TOTAL Ownership			1,409,562	1,409,562		1,409,562	(502,494)	907,068		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		127,138	148,483	275,621		275,621	(1,457)	274,164		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,350	82,350		82,350		82,350		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		127,138	230,833	357,971		357,971	(1,457)	356,514		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,213,491	682,803	3,578,316	7,474,610		7,474,610	(864,669)	6,609,941		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	110,846	30		9
10	Interest and Other Investment Income	(2,076)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(758)	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	(8,126)	21		18
19	Entertainment		20		19
20	Contributions	(7,093)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,942)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,171)	27		24
25	Fund Raising, Advertising and Promotional	(67,305)	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	(117)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,742)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(821,474)		34
35	Other- Attach Schedule	2,547	19	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (818,927)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (864,669)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	COLLECTION FEES	\$ (117)	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	Total	(117)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(758)	0	0	0	0	0	0	0	0	0	0	(758)	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	1,602	0	0	0	0	0	0	0	0	1,602	5
6	Maintenance	0	0	8,663	8,823	0	0	0	0	0	0	0	17,486	6
7	Other (specify):*	0	0	0	0	848	0	0	0	0	0	0	848	7
8	TOTAL General Services	(758)	0	10,265	8,823	848	0	0	0	0	0	0	19,178	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(5,189)	0	0	0	0	0	(5,189)	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	(5,189)	0	0	0	0	0	(5,189)	16
	C. General Administration													
17	Administrative	0	(46,200)	0	150,203	0	0	0	0	0	0	0	104,003	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	488	2,047	743	0	0	0	0	0	0	0	0	3,278	19
20	Fees, Subscriptions & Promotions	(74,398)	0	675	0	0	0	0	0	0	0	0	(73,723)	20
21	Clerical & General Office Expenses	(8,126)	(445,000)	63,841	9,382	0	0	0	0	0	0	0	(379,903)	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	219	0	0	0	0	0	0	0	0	219	24
25	Other Admin. Staff Transportation	0	0	2,956	0	0	0	0	0	0	0	0	2,956	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,083	0	0	0	0	0	0	0	0	1,083	26
27	Other (specify):*	(69,171)	0	14,932	0	21,619	0	0	0	0	0	0	(32,620)	27
28	TOTAL General Administration	(151,207)	(489,153)	84,449	159,585	21,619	0	0	0	0	0	0	(374,707)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(151,965)	(489,153)	94,714	168,408	22,467	(5,189)	0	0	0	0	0	(360,718)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION# 0031823

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	110,846	0	3,103	0	0	0	0	0	0	0	0	113,949	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,076)	326,116	2,945	0	0	0	0	0	0	0	0	326,985	32
33	Real Estate Taxes	0	0	5,476	0	0	0	0	0	0	0	0	5,476	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	9,296	0	0	0	0	0	0	0	0	9,296	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	108,770	(632,084)	20,820	0	0	0	0	0	0	0	0	(502,494)	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	(1,457)	0	0	0	0	0	(1,457)	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	(1,457)	0	0	0	0	0	(1,457)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(43,195)	(1,121,237)	115,534	168,408	22,467	(6,646)	0	0	0	0	0	(864,669)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 BOOKKEEPING SERVICES	\$ 445,000	DYNAMIC HEALTH CARE CONSULTANTS		\$	\$ (445,000)	1
2	V	17 MANAGEMENT FEES	46,200	" " "			(46,200)	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		" " "		326,116	326,116	8
9	V	19 LEGAL & ACCOUNTING		" " "		2,047	2,047	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,449,400			\$ 328,163	\$ * (1,121,237)	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%	\$ 1,602	\$	1,602	15
16	V	6 REPAIR & MAINT.		" " "		8,663		8,663	16
17	V	19 PROFESSIONAL FEES		" " "		743		743	17
18	V	20 DUES AND SUBSCRIPTION		" " "		675		675	18
19	V	21 CLERICAL & GENERAL		" " "		63,841		63,841	19
20	V	24 SEMINARS AND TRAVEL		" " "		219		219	20
21	V	25 AUTO EXPENSE		" " "		2,956		2,956	21
22	V	26 INSURANCE		" " "		1,083		1,083	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		14,932		14,932	23
24	V	30 DEPRECIATION		" " "		3,103		3,103	24
25	V	32 INTEREST		" " "		2,945		2,945	25
26	V	33 REAL ESTATE TAXES		" " "		5,476		5,476	26
27	V	35 EQUIPMENT RENTAL		" " "		9,296		9,296	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		\$			\$ 115,534	\$ *	115,534	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%	\$ 8,823	\$ 8,823	15
16	V	10 DON SALARY - NON OWNER		" " "				16
17	V	17 ADMIN. CMP. - M. MAUER		" " "		24,170	24,170	17
18	V	17 ADMIN. CMP. - M. AARON		" " "		29,861	29,861	18
19	V	17 ADMIN. CMP. - F. AARON		" " "		25,100	25,100	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "				20
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "				21
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		21,559	21,559	22
23	V	17 ADMIN. CMP. - HOWARD ALTER		" " "				23
24	V	17 ADMIN. CMP. - NON-OWNER		" " "		27,633	27,633	24
25	V	17 ADMIN. CMP. - CFO NON-OWNER		" " "		21,880	21,880	25
26	V	21 CLERICAL. CMP. - S. AARON		" " "		9,382	9,382	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		\$			\$ 168,408	\$ * 168,408	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%	\$ 848	\$ 848	15
16	V	17 EMP.BEN. - DON NON OWNER		" " "				16
17	V	27 EMP.BEN. - M. MAUER		" " "		1,704	1,704	17
18	V	27 EMP. BEN. - M. AARON		" " "		2,413	2,413	18
19	V	27 EMP. BEN. - F. AARON		" " "		8,047	8,047	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "				20
21	V	27 EMP. BEN. - S. KOPLIN		" " "				21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		1,403	1,403	22
23	V	27 EMP. BEN. - H. ALTER		" " "				23
24	V	27 EMP. BEN. - NON-OWNER		" " "		3,732	3,732	24
25	V	27 EMP. BEN. - CFO NON-OWNER		" " "		2,574	2,574	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,746	1,746	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		\$			\$ 22,467	\$ * 22,467	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	\$ 55,818	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	\$ 50,629	\$ (5,189)	15
16	V	39 ANCILLARY EXPENSE	15,672	" " "		14,215	(1,457)	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		\$ 71,490			\$ 64,844	\$ * (6,646)	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:

01/01/2008

Ending:

12/31/2008

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	\$ 24,170	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	29,861	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	25,100	17-7	3
4	" "		ADMINISTRATIVE					SALARY	14,500	17-1	4
5	SHARON AARON		CLERICAL					SALARY	9,382	21-7	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	8,823	6-7	6
7	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	21,559	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 133,395		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:

01/01/2008

Ending: **2/31/2008**

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	389,945	11	\$ 12,950	\$ 48,244	\$ 1,602	1
2	6	REPAIR & MAINT.	"	389,945	11	70,023	48,244	8,663	2
3	19	PROFESSIONAL FEES	"	389,945	11	6,008	48,244	743	3
4	20	DUES AND SUBSCRIPTION	"	389,945	11	5,456	48,244	675	4
5	21	CLERICAL & GENERAL	"	389,945	11	516,008	397,203	63,841	5
6	24	SEMINARS AND TRAVEL	"	389,945	11	1,768	48,244	219	6
7	25	AUTO EXPENSE	"	389,945	11	23,890	48,244	2,956	7
8	26	INSURANCE	"	389,945	11	8,755	48,244	1,083	8
9	27	EMP. BEN. - GEN, ADMIN.	"	389,945	11	120,690	48,244	14,932	9
10	30	DEPRECIATION	"	389,945	11	25,083	48,244	3,103	10
11	32	INTEREST	"	389,945	11	23,800	48,244	2,945	11
12	33	REAL ESTATE TAXES	"	389,945	11	44,257	48,244	5,476	12
13	35	EQUIPMENT RENTAL	"	389,945	11	75,134	48,244	9,296	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					\$ 933,822	\$ 397,203	\$ 115,534	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	11	\$ 62,290	\$ 62,290	6	\$ 8,823	1
2	10	DON SALARY - NON OWNER	" "	40	11	73,680	73,680			2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	195,000	195,000	5	24,170	3
4	17	ADMIN. CMP. - M. AARON	" "	40	11	195,000	195,000	6	29,861	4
5	17	ADMIN. CMP. - F. AARON	" "	45	11	125,500	125,500	9	25,100	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	11	75,353	75,353			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	30	11	72,748	72,748			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	50	11	152,220	152,220	7	21,559	8
9	17	ADMIN. CMP. - S. LEVY	" "	40	11	12,000	12,000			9
10	17	ADMIN. CMP. - H. ALTER	" "	45	11	195,473	195,473	6	27,633	10
11	17	ADMIN. CMP. - NON-OWNER	" "	45	11	176,522	176,522	6	21,880	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	11	75,677	75,677	5	9,382	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					\$ 1,411,463	\$ 1,411,463		\$ 168,408	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	\$ 5,985	6	\$ 848	1
2	15	EMP.BEN. - DON NON OWNER	" "	40	11	18,419			2
3	27	EMP.BEN. - M. MAUER	" "	40	11	13,750	5	1,704	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,761	6	2,413	4
5	27	EMP. BEN. - F. AARON	" "	45	11	40,234	9	8,047	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	32,869			6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	23,230			7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	9,910	7	1,403	8
9	27	EMP. BEN. - S. LEVY	" "	40	11	1,129			9
10	27	EMP. BEN. - H. ALTER	" "	45	11	26,397	6	3,732	10
11	27	EMP. BEN. - NON-OWNER	" "	45	11	20,765	6	2,574	11
12	27	EMP. BEN. - S. AARON	" "	40	11	14,086	5	1,746	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					\$ 222,535	\$	\$ 22,467	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 LINCOLN MEDICAL SUPPLEIS
 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	LINCOLN MEDICAL SUPPLIES				\$	\$		\$	1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						50,629	2
3	39 ANCILLARY EXPENSE							14,215	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				\$	\$		\$ 64,844	25

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$55,889.00	10/00	\$ 5,625,000	\$ 3,520,454			8.6500	\$ 326,116						
2																		
3																		
4																		
5	RELATED PARTY											2,945						
Working Capital																		
6	CHASE BANK		X	LINE OF CREDIT				550,459				20,333						
7	FORD CREDIT		X	VAN				5,154				775						
8			X	INSURANCE FINANCING								2,755						
9	TOTAL Facility Related				\$55,889.00		\$ 5,625,000	\$ 4,076,067				\$ 352,924						
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$ 5,625,000	\$ 4,076,067				\$ 352,924						

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 2007 report.		\$	343,000	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.)		\$	334,384	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(8,616)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	341,000	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.		\$	332,384	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	293,113	8
	2004	305,181	9
	2005	314,321	10
	2006	334,205	11
	2007	334,384	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>334,383.88</u>	\$ <u>334,383.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>334,383.88</u>	\$ <u>334,383.88</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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 Use	2 Square Feet	3 Year Acquired	4 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:

01/01/2008 Ending: 12/31/2008

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	\$ 2,019,054	4
5										5
6										6
7										7
8	RELATED PARTY			54,882	1,407		1,568	161	24,043	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1989	6,334	201	31.5	201		3,911	9
10	LEASEHOLD IMPROVEMENT		1990	1,538	49	20	76	27	1,189	10
11	LEASEHOLD IMPROVEMENT		1991	26,695	847	20	1,335	488	20,197	11
12	LEASEHOLD IMPROVEMENT		1992	4,785	152	20	239	87	3,465	12
13	LEASEHOLD IMPROVEMENT		1993	8,024	255	31.5	255		4,020	13
14	LEASEHOLD IMPROVEMENT		1993	36,822	944	39	944		14,501	14
15	LEASEHOLD IMPROVEMENT		1994	38,826	996	39	996		14,137	15
16	LEASEHOLD IMPROVEMENT		1995	21,539	553	39	553		7,555	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996	1,604	41	39	41		525	17
18	ROOF REPAIR		1996	3,800	97	39	97		1,210	18
19	GAZEBO		1996	1,282	33	39	33		408	19
20	ASPHALT REMOVE & REPLACE		1996	2,686	69	39	69		849	20
21	ROOF REPAIR		1996	7,000	180	39	180		2,205	21
22	HOT WATER TANK		1996	12,098	310	39	310		3,758	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997	6,844	175	39	175		1,977	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997	105,092	2,695	39	2,695		40,507	24
25	ROOFING		1997	45,500	1,167	39	1,167		13,180	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997	4,721	121	39	121		1,366	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997	26,497	679	39	679		7,658	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998	3,359	86	39	86		896	28
29	DRAPES & INSTALLATION		1998	5,965	153	39	153		1,585	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998	14,240	365	39	365		3,784	30
31	EXHAUST FAN & INSTALLATION		1998	2,285	59	39	59		602	31
32	ROOF REPAIR		1998	8,750	224	39	224		2,326	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998	22,500	577	39	577		6,002	33
34	ELECTRICAL WORK		1998	5,376	138	39	138		1,429	34
35	COUNTER TOPS		1998	712	18	39	18		86	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:

01/01/2008 Ending: 12/31/2008

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		\$ 305	37
38	NURSES STATION	1999	16,601	426	39	426		4,242	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		1,118	39
40	FIRE SYSTEM	1999	2,625	67	39	67		666	40
41	FLOOR TILE	1999	10,807	277	39	277		3,759	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		2,392	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		2,154	43
44	AIR CONDITIONING	1999	14,451	371	39	371		3,597	44
45	RAILINGS	1999	3,282	84	39	84		809	45
46	ROOF WORK	1999	4,500	115	39	115		1,069	46
47	NURSE STATION	2000	7,090	258	27.5	258		2,205	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		1,978	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		2,605	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		803	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		1,076	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	3,135	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		1,520	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		1,546	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		779	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		1,538	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		646	57
58	CONCRETE PAD	2002	1,662	69	15	111	42	720	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		165	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		828	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		1,287	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		453	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		420	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		1,591	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		620	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		3,085	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		2,202	67
68	AIR CONDITIONING	2004	664	24	27.5	24		107	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,862,128	\$ 18,847		\$ 126,108	\$ 107,261	\$ 2,251,845	70

**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:

01/01/2008 Ending: 12/31/2008

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		\$ 3,862,128	\$ 18,847		\$ 126,108	\$ 107,261	\$ 2,251,845	1
2	WATER HEATER, VALVE & PUMPS	2004	6,594	240	27.5	240		1,070	2
3	FIRE DOORS	2004	769	28	27.5	28		125	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		961	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		1,329	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		183	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		238	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		256	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		290	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		253	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		3,235	11
12	LANDSCAPING	2006	10,250	683	15	683		1,708	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		88	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		580	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		118	15
16	REPAIR FENCE	2006	2,000	133	15	133		332	16
17	FIRE DOORS	2006	1,058	39	27.5	39		96	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		197	18
19	GAZEBO	2007	4,671	311	15	311		467	19
20	DISH NETWORK CABLING	2007	19,000	691	27.5	691		1,008	20
21	WALL AIR CONDITIONER	2007	3,374	123	27.5	123		179	21
22	SECURITY DOORS	2007	4,837	176	27.5	176		257	22
23	PARKING LOT PAVING	2007	4,492	163	27.5	163		238	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	83	27.5	83		121	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	140	27.5	140		204	25
26	CAMERA SYSTEM	2008	8,020	133	27.5	133		133	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350	39	27.5	39		39	27
28	WALLPAPER & PLASTERING	2008	14,140	236	27.5	236		236	28
29	AC/HEATER UNITS	2008	6,221	104	27.5	104		104	29
30	DOOR & FRAME	2008	2,113	35	27.5	35		35	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340	256	27.5	256		256	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,406	\$ 25,263		\$ 132,524	\$ 107,261	\$ 2,266,181	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:

01/01/2008

Ending:

12/31/2008

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	\$ 524,123	\$ 37,088	\$ 48,223	\$ 11,135	10 YRS	\$ 330,827	71
72	Current Year Purchases	34,140	20,484	1,707	(18,777)	10 YRS	1,707	72
73	Fully Depreciated Assets	259,486					259,486	73
74	RELATED PARTY	107,257	108	2,005	1,897	5-10 YRS	100,452	74
75	TOTALS	\$ 925,006	\$ 57,680	\$ 51,935	\$ (5,745)		\$ 692,472	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	\$ 38,777	76
77	RELATED PARTY			34,701	1,588	4,783	3,195		18,932	77
78										78
79										79
80	TOTALS			\$ 77,786	\$ 4,070	\$ 13,400	\$ 9,330		\$ 57,709	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)	\$ 5,446,019	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,013	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,859	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 110,846	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,016,362	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: \$ 11,205 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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	\$		\$ 60,334	\$		\$ 60,334	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,232			1,232	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			86,917			86,917	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				97,405		97,405	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	SUPPLIES, RADIOLOGY, LAB, OTHER Other (specify):	39-2					29,733		29,733	13
14	TOTAL			\$		\$ 148,483	\$ 127,138		\$ 275,621	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 154,896	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 296,000)	1,055,660		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,418		6
7	Other Prepaid Expenses	3,099		7
8	Accounts Receivable (owners or related parties)	80,124		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,382,197	\$	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	791,536		15
16	Equipment, at Historical Cost	860,832		16
17	Accumulated Depreciation (book methods)	(1,001,595)		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): DEPOSIT/HOUSE	291,611		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 942,384	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,324,581	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 371,927	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	655,613		29
30	Accrued Salaries Payable	292,786		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,275		31
32	Accrued Real Estate Taxes(Sch.IX-B)	341,000		32
33	Accrued Interest Payable	1,185		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)	\$ 1,680,786	\$	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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,680,786	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 643,795	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,324,581	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 990,917	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 990,917	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(347,122)	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)	\$ (347,122)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 643,795	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	\$ 6,776,592	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,776,592	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	348,820	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 348,820	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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,076	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,076	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,127,488	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,106,165	31
32	Health Care	2,793,366	32
33	General Administration	1,807,546	33
	B. Capital Expense		
34	Ownership	1,409,562	34
	C. Ancillary Expense		
35	Special Cost Centers	275,621	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,474,610	40
41	Income before Income Taxes (line 30 minus line 40)**	(347,122)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (347,122)	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: 01/01/2008

Ending:

12/31/2008

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	1,606	2,004	\$ 83,606	\$ 41.72	1
2	Assistant Director of Nursing	2,517	2,868	73,776	25.72	2
3	Registered Nurses	5,784	5,980	157,420	26.32	3
4	Licensed Practical Nurses	34,209	37,421	866,950	23.17	4
5	CNAs & Orderlies	80,533	86,863	961,822	11.07	5
6	CNA Trainees					6
7	Licensed Therapist	7,370	7,646	269,253	35.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,881	2,117	28,363	13.40	9
10	Activity Assistants	7,959	8,747	78,611	8.99	10
11	Social Service Workers	2,565	2,898	43,722	15.09	11
12	Dietician					12
13	Food Service Supervisor	1,978	2,195	42,494	19.36	13
14	Head Cook	3,910	4,207	49,528	11.77	14
15	Cook Helpers/Assistants	13,819	15,213	149,045	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,885	4,326	78,982	18.26	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,954	2,191	78,433	35.80	20
21	Assistant Administrator	2,377	2,612	64,051	24.52	21
22	Other Administrative	468	468	14,500	30.98	22
23	Office Manager					23
24	Clerical	8,092	8,787	145,860	16.60	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	1,663	2,009	27,075	13.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,570	198,552	\$ 3,213,491 *	\$ 16.18	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	278	\$ 8,880	1-3	35
36	Medical Director	12	600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	121	5,082	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	36	1,776	11-3	44
45	Social Service Consultant	47	2,558	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	494	\$ 18,896		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

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 \$10,950 IL ASSOC HC FAC \$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. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,350
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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