

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	1,430		3,466	4,896	8
9	SNF/PED					9
10	ICF	37,975	1,752	1,526	41,253	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,405	1,752	4,992	46,149	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.29%

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 150 and days of care provided 3,466

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	244,451	11,931	9,180	265,562		265,562		265,562		1
2	Food Purchase		214,017		214,017		214,017	(1,022)	212,995		2
3	Housekeeping		21,951	155,664	177,615		177,615		177,615		3
4	Laundry		14,738	87,969	102,707		102,707		102,707		4
5	Heat and Other Utilities			135,120	135,120		135,120	1,562	136,682		5
6	Maintenance	75,302	46,758	15,610	137,670		137,670	16,358	154,028		6
7	Other (specify):*			13,362	13,362		13,362	826	14,188		7
8	TOTAL General Services	319,753	309,395	416,905	1,046,053		1,046,053	17,724	1,063,777		8
	B. Health Care and Programs										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	2,172,340	102,949	5,922	2,281,211		2,281,211	(4,634)	2,276,577		10
10a	Therapy	436,030	2,031		438,061		438,061		438,061		10a
11	Activities	101,748	8,666	2,212	112,626		112,626		112,626		11
12	Social Services	58,349		1,904	60,253		60,253		60,253		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,768,467	113,646	10,638	2,892,751		2,892,751	(4,634)	2,888,117		16
	C. General Administration										
17	Administrative	159,224		55,200	214,424		214,424	88,572	302,996		17
18	Directors Fees										18
19	Professional Services			119,580	119,580		119,580	832	120,412		19
20	Dues, Fees, Subscriptions & Promotions			71,081	71,081		71,081	(54,816)	16,265		20
21	Clerical & General Office Expenses	159,089	19,768	480,249	659,106		659,106	(398,547)	260,559		21
22	Employee Benefits & Payroll Taxes			490,499	490,499		490,499		490,499		22
23	Inservice Training & Education			1,387	1,387		1,387		1,387		23
24	Travel and Seminar							681	681		24
25	Other Admin. Staff Transportation			3,573	3,573		3,573	639	4,212		25
26	Insurance-Prop.Liab.Malpractice			181,813	181,813		181,813	1,795	183,608		26
27	Other (specify):*			75,000	75,000		75,000	(35,974)	39,026		27
28	TOTAL General Administration	318,313	19,768	1,478,382	1,816,463		1,816,463	(396,818)	1,419,645		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,406,533	442,809	1,905,925	5,755,267		5,755,267	(383,728)	5,371,539		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
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	55,200
		55,200
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,103
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	105,477
		0
		119,580
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	50,801
	EMPLOYEE WANT ADS XIX F	3,074
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,735
	LICENSES & PERMITS XIX F	2,668
	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	4,623
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	70
	PATIENT BACKGROUND CHECKS XIX F	110
		71,081
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	20,615
	OUTSIDE CLERICAL SERVICES	426,800
	PENALTIES / OVERDRAFT CHARGES VI 18	19,767
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,067
	MESSENGER SERVICE	0
		0
		480,249

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	227,984
	UNEMPLOYMENT COMPENSATION XIX D	58,117
	WORKERS COMPENSATION INSURANCE XIX D	75,005
	HOSPITALIZATION INSURANCE XIX D	119,613
	EMPLOYEE BENEFITS - OTHER XIX D	9,780
	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
		490,499
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,387
		1,387
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,573
		3,573
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	181,813
		181,813
27	OTHER	
	BAD DEBTS VI 24	75,000
		75,000

GRAND TOTAL COLUMN 3 OTHER

1,905,925

**WINDMILL NURSING PAVILION
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	214,017
LESS SALES TAX	<u>(1,022)</u>
NET FOOD	212,995
TOTAL PATIENT CENSUS	46,149
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	138,447
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	138,447
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	138,447
NET FOOD	212,995
DIVIDE TOTAL MEALS/YEAR	<u>138,447</u>
COST PER MEAL	1.54
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

WINDMILL NURSING PAVILION

#0031823

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			72,956	72,956		72,956	126,093	199,049			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,586	32,586		32,586	295,038	327,624			32
33	Real Estate Taxes			334,698	334,698		334,698	4,690	339,388			33
34	Rent-Facility & Grounds			827,825	827,825		827,825	(827,825)				34
35	Rent-Equipment & Vehicles			15,706	15,706		15,706	8,741	24,447			35
36	Other (specify):*											36
37	TOTAL Ownership			1,283,771	1,283,771		1,283,771	(393,263)	890,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,788	33,768	158,556		158,556	(1,333)	157,223			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	TOTAL Special Cost Centers		124,788	115,893	240,681		240,681	(1,333)	239,348			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,406,533	567,597	3,305,589	7,279,719		7,279,719	(778,324)	6,501,395			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	121,792	30		9
10	Interest and Other Investment Income	(2,359)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,022)	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	(19,767)	21		18
19	Entertainment		20		19
20	Contributions	(4,623)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(306)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,000)	27		24
25	Fund Raising, Advertising and Promotional	(50,801)	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	(26,981)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,067)		\$	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)	(719,257)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (719,257)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (778,324)		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.

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0031823
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARIES	\$ -26981	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(26,981)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,022)	0	0	0	0	0	0	0	0	0	0	(1,022)	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	1,562	0	0	0	0	0	0	0	0	1,562	5
6	Maintenance	0	0	7,961	8,397	0	0	0	0	0	0	0	16,358	6
7	Other (specify):*	0	0	0	0	826	0	0	0	0	0	0	826	7
8	TOTAL General Services	(1,022)	0	9,523	8,397	826	0	0	0	0	0	0	17,724	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	(4,634)	0	0	0	0	0	(4,634)	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	(4,634)	0	0	0	0	0	(4,634)	16
	C. General Administration													
17	Administrative	0	(55,200)	0	143,772	0	0	0	0	0	0	0	88,572	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(306)	0	1,138	0	0	0	0	0	0	0	0	832	19
20	Fees, Subscriptions & Promotions	(55,424)	0	608	0	0	0	0	0	0	0	0	(54,816)	20
21	Clerical & General Office Expenses	(46,748)	(426,800)	64,624	10,377	0	0	0	0	0	0	0	(398,547)	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	681	0	0	0	0	0	0	0	0	681	24
25	Other Admin. Staff Transportation	0	0	639	0	0	0	0	0	0	0	0	639	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,795	0	0	0	0	0	0	0	0	1,795	26
27	Other (specify):*	(75,000)	0	12,549	0	26,477	0	0	0	0	0	0	(35,974)	27
28	TOTAL General Administration	(177,478)	(482,000)	82,034	154,149	26,477	0	0	0	0	0	0	(396,818)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(178,500)	(482,000)	91,557	162,546	27,303	(4,634)	0	0	0	0	0	(383,728)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	121,792	0	4,301	0	0	0	0	0	0	0	0	126,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,359)	293,526	3,871	0	0	0	0	0	0	0	0	295,038	32
33	Real Estate Taxes	0	0	4,690	0	0	0	0	0	0	0	0	4,690	33
34	Rent-Facility & Grounds	0	(827,825)	0	0	0	0	0	0	0	0	0	(827,825)	34
35	Rent-Equipment & Vehicles	0	0	8,741	0	0	0	0	0	0	0	0	8,741	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	119,433	(534,299)	21,603	0	0	0	0	0	0	0	0	(393,263)	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	(1,333)	0	0	0	0	0	(1,333)	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	(1,333)	0	0	0	0	0	(1,333)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(59,067)	(1,016,299)	113,160	162,546	27,303	(5,967)	0	0	0	0	0	(778,324)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 55,200	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$	\$ (55,200)	1
2	V	21	BOOKKEEPING SERVICES	426,800	" " "			(426,800)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	827,825	16000 S WABASH LLC	100.00%		(827,825)	7
8	V	32	INTEREST		" " "		293,526	293,526	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,309,825			\$ 293,526	\$ *	(1,016,299)	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 HEALTH CARE CONSULTANTS	100.00%	\$ 1,562	\$ 1,562
16	V	6 REPAIR & MAINT.		" " "		7,961	7,961
17	V	19 PROFESSIONAL FEES		" " "		1,138	1,138
18	V	20 DUES AND SUBSCRIPTION		" " "		608	608
19	V	21 CLERICAL & GENERAL		" " "		64,624	64,624
20	V	24 SEMINARS AND TRAVEL		" " "		681	681
21	V	25 AUTO EXPENSE		" " "		639	639
22	V	26 INSURANCE		" " "		1,795	1,795
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		12,549	12,549
24	V	30 DEPRECIATION		" " "		4,301	4,301
25	V	32 INTEREST		" " "		3,871	3,871
26	V	33 REAL ESTATE TAXES		" " "		4,690	4,690
27	V	35 EQUIPMENT RENTAL		" " "		8,741	8,741
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 113,160	\$ * 113,160

* 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 COMP - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 8,397	\$ 8,397
16	V	17 ADMIN COMP - M MAUER		" " "		22,908	22,908
17	V	17 ADMIN COMP - M AARON		" " "		25,978	25,978
18	V	17 ADMIN COMP - F AARON		" " "		21,200	21,200
19	V	17 ADMIN COMP - S GOLDSTEIN		" " "			
20	V	17 ADMIN COMP - J AARON		" " "			
21	V	17 ADMIN COMP - S KOPLIN		" " "			
22	V	17 ADMIN COMP - D MAGAFAS		" " "		21,369	21,369
23	V	17 ADMIN COMP - HOWARD ALTER		" " "			
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" " "			
25	V	17 ADMIN COMP - NON OWNER - VAR		" " "		28,757	28,757
26	V	17 ADMIN COMP - NON OWNER - CFO		" " "		23,560	23,560
27	V	21 CLERICAL COMP - S AARON		" " "		10,377	10,377
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 162,546	\$ * 162,546

* 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 HEALTH CARE CONSULTANTS	100.00%	\$ 826	\$ 826	15	
16	V	27	EMP BEN - M MAUER		" " "		1,644	1,644	16	
17	V	27	EMP BEN - M AARON		" " "		2,145	2,145	17	
18	V	27	EMP BEN - F AARON		" " "		8,736	8,736	18	
19	V	27	EMP BEN - S GOLDSTEIN		" " "				19	
20	V	27	EMP BEN - J AARON		" " "				20	
21	V	27	EMP BEN - S KOPLIN		" " "				21	
22	V	27	EMP BEN - D MAGAFAS		" " "		1,384	1,384	22	
23	V	27	EMP BEN - HOWARD ALTER		" " "				23	
24	V	27	EMP BEN - V DAVIS		" " "				24	
25	V	27	EMP BEN - NON OWNER		" " "		8,115	8,115	25	
26	V	27	EMP BEN - NON OWNER - CFO		" " "		2,606	2,606	26	
27	V	27	EMP BEN - S AARON		" " "		1,847	1,847	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			\$			\$ 27,303	\$ *	27,303	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	\$ 42,927	LINCOLN MEDICAL SUPPLIES INC	100.00%	\$ 38,293	\$ (4,634)	15
16	V	39	ANCILLARY EXPENSE	12,351	" " "		11,018	(1,333)	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			\$ 55,278			\$ 49,311	\$ * (5,967)	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:

01/01/2009

Ending:

12/31/2009

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	\$ 22,908	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	25,978	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	21,200	17-7	3
4	" "		ADMINISTRATIVE					SALARY	6,000	17-1	4
5	SHARON AARON		CLERICAL					SALARY	10,377	21-7	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	8,397	6-7	6
7	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	21,369	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 116,229		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:

01/01/2009

Ending: 2/31/2009

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 HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN ST
 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	REPAIR & MAINT.	TOTAL PATIENT DAYS	393,498	11	\$ 13,322	\$ 46,149	\$ 1,562	1
2	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	393,498	11	67,883	46,149	7,961	2
3	20	DUES AND SUBSCRIPTION	TOTAL PATIENT DAYS	393,498	11	9,699	46,149	1,138	3
4	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	393,498	11	5,183	46,149	608	4
5	24	SEMINARS AND TRAVEL	TOTAL PATIENT DAYS	393,498	11	551,031	404,350	64,624	5
6	25	AUTO EXPENSE	TOTAL PATIENT DAYS	393,498	11	5,810	46,149	681	6
7	26	INSURANCE	TOTAL PATIENT DAYS	393,498	11	5,452	46,149	639	7
8	27	EMP. BEN. - GEN, ADMIN.	TOTAL PATIENT DAYS	393,498	11	15,305	46,149	1,795	8
9	30	DEPRECIATION	TOTAL PATIENT DAYS	393,498	11	107,005	46,149	12,549	9
10	32	INTEREST	TOTAL PATIENT DAYS	393,498	11	36,672	46,149	4,301	10
11	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	393,498	11	33,003	46,149	3,871	11
12	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	393,498	11	39,991	46,149	4,690	12
13		TOTAL PATIENT DAYS	393,498	11	74,530		46,149	8,741	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					\$ 964,886	\$ 404,350	\$ 113,160	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN ST
 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 COMP - D NEHMER	WGHTD AVG HOURS	40	8	\$ 63,031	\$ 63,031	5	\$ 8,397	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	195,000	195,000	5	22,908	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	195,000	195,000	5	25,978	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	106,000	106,000	9	21,200	4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	94,542	94,542			5
6	17	ADMIN COMP - J AARON	WGHTD AVG HOURS	40	1	2,657	2,657			6
7	17	ADMIN COMP - S KOPLIN	WGHTD AVG HOURS	30	3	73,196	73,196			7
8	17	ADMIN COMP - D MAGAFAS	WGHTD AVG HOURS	50	8	160,425	160,425	7	21,369	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	1	74,152	74,152			10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	216,303	216,303	6	28,757	11
12	17	ADMIN COMP - NON OWNER - CI	WGHTD AVG HOURS	45	10	200,543	200,543	5	23,560	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	88,338	88,338	5	10,377	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					\$ 1,481,187	\$ 1,481,187		\$ 162,546	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN ST
 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	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	\$ 6,197	\$ 5	\$ 826	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	13,995	5	1,644	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	16,097	5	2,145	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	43,678	9	8,736	4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,728			5
6	27	EMP BEN - J AARON	WGHTD AVG HOURS	40	1				6
7	27	EMP BEN - S KOPLIN	WGHTD AVG HOURS	30	3	25,540			7
8	27	EMP BEN - D MAGAFAS	WGHTD AVG HOURS	50	8	10,394	7	1,384	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,079			9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	1	17,756			10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	61,038	6	8,115	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,185	5	2,606	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	15,719	5	1,847	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					\$ 271,406	\$	\$ 27,303	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 LINCOLN MEDICAL SUPPLIES
 Street Address 3359 W MAIN ST
 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	10	MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 38,293	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					11,018	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 49,311	25

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	CHASE BANK		X	MORTGAGE	\$55,899.00	10/00	\$ 5,625,000	\$ 3,143,353		8.6500	\$ 293,526	1							
2												2							
3												3							
4												4							
5	RELATED PARTY	X									3,871	5							
	Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	\$5,848.00	7/10/08	300,000	242,706	7/10/13	6.2500	12,878	6							
7	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	7/10/08	600,000	600,000	7/10/10	4.2500	15,959	7							
8			X	AUTO/INS FINANCING							3,749	8							
9	TOTAL Facility Related				\$61,747.00		\$ 6,525,000	\$ 3,986,059			\$ 329,983	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 6,525,000	\$ 3,986,059			\$ 329,983	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

1. Real Estate Tax accrual used on 2008 report.		\$	341,000	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.)		\$	334,698	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(6,302)	3
4. Real Estate Tax accrual used for 2009 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.		\$	334,698	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	305,181	8
	2005	314,321	9
	2006	334,205	10
	2007	334,384	11
	2008	334,698	12
2009 REAL ESTATE TAX ACCRUAL BASED ON 102% OF THE 2008 REAL ESTATE TAX BILL			

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(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>334,697.93</u>	\$ <u>334,697.93</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>334,697.93</u>	\$ <u>334,697.93</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number WINDMILL NURSING PAVILION# 0031823

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	\$ 2,125,320	4
5											5
6											6
7											7
8	RELATED PARTY				52,025	1,334	35	1,486	152	24,278	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT		1989		6,334	201	31.5	201		4,112	9
10	LEASEHOLD IMPROVEMENT		1990		1,538	49	20	76	27	1,265	10
11	LEASEHOLD IMPROVEMENT		1991		26,695	847	20	1,335	488	21,532	11
12	LEASEHOLD IMPROVEMENT		1992		4,785	152	20	239	87	3,704	12
13	LEASEHOLD IMPROVEMENT		1993		8,024	255	31.5	255		4,275	13
14	LEASEHOLD IMPROVEMENT		1993		36,822	944	39	944		15,445	14
15	LEASEHOLD IMPROVEMENT		1994		38,826	996	39	996		15,133	15
16	LEASEHOLD IMPROVEMENT		1995		21,539	553	39	553		8,108	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996		1,604	41	39	41		566	17
18	ROOF REPAIR		1996		3,800	97	39	97		1,307	18
19	GAZEBO		1996		1,282	33	39	33		441	19
20	ASPHALT REMOVE & REPLACE		1996		2,686	69	39	69		918	20
21	ROOF REPAIR		1996		7,000	180	39	180		2,385	21
22	HOT WATER TANK		1996		12,098	310	39	310		4,068	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997		6,844	175	39	175		2,152	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997		105,092	2,695	39	2,695		43,202	24
25	ROOFING		1997		45,500	1,167	39	1,167		14,347	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997		4,721	121	39	121		1,487	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997		26,497	679	39	679		8,337	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998		3,359	86	39	86		982	28
29	DRAPES & INSTALLATION		1998		5,965	153	39	153		1,738	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998		14,240	365	39	365		4,149	30
31	EXHAUST FAN & INSTALLATION		1998		2,285	59	39	59		661	31
32	ROOF REPAIR		1998		8,750	224	39	224		2,550	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998		22,500	577	39	577		6,579	33
34	ELECTRICAL WORK		1998		5,376	138	39	138		1,567	34
35	COUNTER TOPS		1998		712	18	39	18		104	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT IMPROVEMENT	1998	\$ 1,185	\$ 31	39	\$ 31	\$	\$ 336	37
38	NURSES STATION	1999	16,601	426	39	426		4,668	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		1,240	39
40	FIRE SYSTEM	1999	2,625	67	39	67		733	40
41	FLOOR TILE	1999	10,807	277	39	277		4,036	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		2,638	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		2,381	43
44	AIR CONDITIONING	1999	14,451	371	39	371		3,968	44
45	RAILINGS	1999	3,282	84	39	84		893	45
46	ROOF WORK	1999	4,500	115	39	115		1,184	46
47	NURSE STATION	2000	7,090	258	27.5	258		2,463	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		2,209	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		2,909	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		897	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		1,202	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	3,553	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		1,726	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		1,755	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		885	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		1,746	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		734	57
58	CONCRETE PAD	2002	1,662	69	15	111	42	831	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		191	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		963	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		1,489	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		536	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		497	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		1,882	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		759	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		3,777	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		2,696	67
68	AIR CONDITIONING	2004	664	24	27.5	24		131	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,859,271	\$ 18,774		\$ 126,026	\$ 107,252	\$ 2,376,620	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:

01/01/2009 Ending: 12/31/2009

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,859,271	\$ 18,774		\$ 126,026	\$ 107,252	\$ 2,376,620	1
2	WATER HEATER, VALVE & PUMPS	2004	6,594	240	27.5	240		1,310	2
3	FIRE DOORS	2004	769	28	27.5	28		153	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		1,239	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		1,713	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		236	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		307	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		360	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		408	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		356	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		4,529	11
12	LANDSCAPING	2006	10,250	683	15	683		2,391	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		124	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		816	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		166	15
16	REPAIR FENCE	2006	2,000	133	15	133		465	16
17	FIRE DOORS	2006	1,058	39	27.5	39		135	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		277	18
19	GAZEBO	2007	4,671	311	15	311		778	19
20	DISH NETWORK CABLING	2007	19,000	691	27.5	691		1,699	20
21	WALL AIR CONDITIONER	2007	3,374	123	27.5	123		302	21
22	SECURITY DOORS	2007	4,837	176	27.5	176		433	22
23	PARKING LOT PAVING	2007	4,492	163	27.5	163		401	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	83	27.5	83		204	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	140	27.5	140		344	25
26	CAMERA SYSTEM	2008	8,020	292	27.5	292		425	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350	85	27.5	85		124	27
28	WALLPAPER & PLASTERING	2008	14,140	514	27.5	514		750	28
29	AC/HEATER UNITS	2008	6,221	226	27.5	226		330	29
30	DOOR & FRAME	2008	2,113	77	27.5	77		112	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340	558	27.5	558		814	31
32	DISH NETWORK EQUIPMENT	2009	3,748	62	27.5	62		62	32
33	AC / HEAT WALL UNITS	2009	5,321	89	27.5	89		89	33
34	TOTAL (lines 1 thru 33)		\$ 4,040,618	\$ 26,290		\$ 133,542	\$ 107,252	\$ 2,398,472	34

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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		\$ 4,040,618	\$ 26,290		\$ 133,542	\$ 107,252	\$ 2,398,472	1
2	2009	33,206	553	27.5	553		553	2
3	2009	9,610	160	27.5	160		160	3
4	2009	9,355	156	27.5	156		156	4
5	2009	1,108	18	27.5	18		18	5
6	2009	41,872	698	27.5	698		698	6
7	2009	13,689	228	27.5	228		228	7
8	2009	25,956	433	27.5	433		433	8
9	2009	206,165	3,437	27.5	3,437		3,437	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		\$ 4,381,579	\$ 31,973		\$ 139,225	\$ 107,252	\$ 2,404,155	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:

01/01/2009

Ending:

12/31/2009

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	\$ 523,595	\$ 26,449	\$ 45,035	\$ 18,586	10 YRS	\$ 342,902	71
72	Current Year Purchases	24,379	14,627	1,219	(13,408)	10 YRS	1,219	72
73	Fully Depreciated Assets	294,154					294,154	73
74	RELATED PARTY	91,756		1,153	1,153		21,459	74
75	TOTALS	\$ 933,884	\$ 41,076	\$ 47,407	\$ 6,331		\$ 659,734	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			\$ 23,220	\$ 2,967	\$ 3,800	\$ 833		\$ 4,856	76
77	FACILITY	2004 FORD E 450	2004	43,085	1,241	8,617	7,376	5YRS	47,394	77
78										78
79										79
80	TOTALS			\$ 66,305	\$ 4,208	\$ 12,417	\$ 8,209		\$ 52,250	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)	\$ 5,790,589	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,257	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,049	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 121,792	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,116,139	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?

16. Rental Amount for movable equipment: \$ 15,706 Description: YES NO 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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			19,745			19,745	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				109,328		109,328	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>SUPPLIES, LAB, XRAY, OTHER</u>					14,023	15,460		29,483	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 33,768	\$ 124,788		\$ 158,556	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: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 366,000)	880,615		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,302		6
7	Other Prepaid Expenses	7,623		7
8	Accounts Receivable (owners or related parties)	231,836		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,227,376	\$	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	1,141,566		15
16	Equipment, at Historical Cost	885,211		16
17	Accumulated Depreciation (book methods)	(1,074,551)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>INVESTMENT HOUSE</u>	95,560		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,047,786	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,275,162	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 338,636	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	842,703		29
30	Accrued Salaries Payable	312,104		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,684		31
32	Accrued Real Estate Taxes(Sch.IX-B)	341,000		32
33	Accrued Interest Payable	1,165		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)	\$ 1,854,292	\$	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)	\$ 1,854,292	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 420,870	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,275,162	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 643,796	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 643,796	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(222,926)	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)	\$ (222,926)	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)	\$ 420,870	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	\$ 6,829,006	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,829,006	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	339,883	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 339,883	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***	2,359	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,359	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	25,836	27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,836	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,197,084	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,046,053	31
32	Health Care	2,892,751	32
33	General Administration	1,816,463	33
B. Capital Expense			
34	Ownership	1,283,771	34
C. Ancillary Expense			
35	Special Cost Centers	158,556	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	139,160	37
38	RE TAX HOUSE	1,131	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,420,010	40
41	Income before Income Taxes (line 30 minus line 40)**	(222,926)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (222,926)	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:

01/01/2009

Ending:

12/31/2009

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	2,044	2,156	\$ 96,871	\$ 44.93	1
2	Assistant Director of Nursing	1,522	1,755	42,111	23.99	2
3	Registered Nurses	5,051	5,387	137,662	25.55	3
4	Licensed Practical Nurses	36,124	39,377	922,759	23.43	4
5	CNAs & Orderlies	79,879	87,292	944,282	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,619	12,507	436,030	34.86	8
9	Activity Director	1,807	2,067	27,455	13.28	9
10	Activity Assistants	8,003	8,168	74,293	9.10	10
11	Social Service Workers	3,047	3,310	58,349	17.63	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,206	41,373	18.75	13
14	Head Cook	5,689	6,137	70,907	11.55	14
15	Cook Helpers/Assistants	11,146	12,287	132,171	10.76	15
16	Dishwashers					16
17	Maintenance Workers	3,666	4,054	75,302	18.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,973	2,211	102,610	46.41	20
21	Assistant Administrator	2,032	2,292	56,614	24.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,056	9,060	159,089	17.56	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	1,748	1,965	28,655	14.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,354	202,231	\$ 3,406,533 *	\$ 16.84	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	\$ 9,180	1-3	35
36	Medical Director	600	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	5,922	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	40	11-3	44
45	Social Service Consultant	38	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	78	\$ 19,818	49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$6,950 IL ASSOC OF HC \$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. \$ 82,125
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. \$ 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: _____
- (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.