FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0031823

Facility Name: WINDMILL NURSING PAVILION

Address: 16000 SOUTH WABASH (Number) SOUTH HOLLAND (City) 60473 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 01/02/1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,183	3,183	8
9	SNF/PED					9
10	ICF	41,240	1,512		42,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,240	1,512	3,183	45,935	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.67%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 01/02/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 3,183

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		2,409	561,381	563,790		563,790		563,790			1
2	Food Purchase		639		639		639	(639)				2
3	Housekeeping		90	181,066	181,156		181,156		181,156			3
4	Laundry		8,623	97,435	106,058		106,058		106,058			4
5	Heat and Other Utilities			113,321	113,321		113,321	1,307	114,628			5
6	Maintenance	87,203	42,269	19,987	149,459		149,459	19,030	168,489			6
7	Other (specify):*			11,237	11,237		11,237	1,054	12,291			7
8	TOTAL General Services	87,203	54,030	984,427	1,125,660		1,125,660	20,752	1,146,412			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,438,917	141,946	9,257	2,590,120		2,590,120		2,590,120			10
10a	Therapy	358,895	4,771		363,666		363,666		363,666			10a
11	Activities	110,816	10,402	2,080	123,298		123,298		123,298			11
12	Social Services	63,954		4,410	68,364		68,364		68,364			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,972,582	157,119	21,747	3,151,448		3,151,448		3,151,448			16
	C. General Administration											
17	Administrative	132,913		55,200	188,113		188,113	112,736	300,849			17
18	Directors Fees											18
19	Professional Services			76,985	76,985		76,985	695	77,680			19
20	Dues, Fees, Subscriptions & Promotions			82,201	82,201		82,201	(59,661)	22,540			20
21	Clerical & General Office Expenses	200,586	22,555	464,133	687,274		687,274	(393,447)	293,827			21
22	Employee Benefits & Payroll Taxes			540,124	540,124		540,124		540,124			22
23	Inservice Training & Education			6,624	6,624		6,624		6,624			23
24	Travel and Seminar							3,023	3,023			24
25	Other Admin. Staff Transportation			7,433	7,433		7,433	82	7,515			25
26	Insurance-Prop.Liab.Malpractice			237,522	237,522		237,522		237,522			26
27	Other (specify):*			28,474	28,474		28,474	15,490	43,964			27
28	TOTAL General Administration	333,499	22,555	1,498,696	1,854,750		1,854,750	(321,082)	1,533,668			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,393,284	233,704	2,504,870	6,131,858		6,131,858	(300,330)	5,831,528			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WINDMILL NURSING PAVILION #0031823 **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		561,381	561,381
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SVC		181,066	
			0	181,066
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,002	
	CINTRACTED LAUNDRY SERVICES		95,433	97,435
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,524	
	ELECTRICITY		62,196	
	WATER		25,511	
	CABLE TV - LOBBY		2,090	
			0	113,321
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,840	
	PAINTING & DECORATING		659	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,063	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,425	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	19,987
7	**OTHER**			
	SCAVENGER		11,237	
	SECURITY SERVICE		0	
			0	
			0	11,237
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

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	9,257	
	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	9,257
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,080	
			0	2,080
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,410	
				4,410
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	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	25,062	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	51,923	
			0	76,985
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	59,226	
	EMPLOYEE WANT ADS	XIX F	427	
	CONTRIBUTIONS	VI 20 XIX F	250	
	DUES & SUBSCRIPTIONS	XIX F	16,284	
	LICENSES & PERMITS	XIX F	3,264	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,750	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				82,201
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,295	
	EQUIPMENT REPAIR & MAINTENANCE		15,940	
	OUTSIDE CLERICAL SERVICES		431,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	100	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,798	
	MESSENGER SERVICE		0	
			0	464,133

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	257,028	
	UNEMPLOYMENT COMPENSATION	XIX D	42,063	
	WORKERS COMPENSATION INSURANC	XIX D	98,007	
	HOSPITALIZATION INSURANCE	XIX D	125,593	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,433	
	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	540,124
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,624	
				6,624
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,433	
				7,433
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		237,522	
				237,522
27	**OTHER**			
	BAD DEBTS	VI 24	28,474	
				28,474

GRAND TOTAL COLUMN 3 OTHER **2,504,870**

WINDMILL NURSING PAVILION
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	639
LESS SALES TAX	(639)
NET FOOD	0
TOTAL PATIENT CENSUS	45,935
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	137,805
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	137,805
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	137,805
NET FOOD	0
DIVIDE TOTAL MEALS/YEAR	137,805
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,452	65,452		65,452	128,815	194,267			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,395	43,395		43,395	164,342	207,737			32
33	Real Estate Taxes			459,041	459,041		459,041	4,230	463,271			33
34	Rent-Facility & Grounds			840,000	840,000		840,000	(840,000)				34
35	Rent-Equipment & Vehicles			3,895	3,895		3,895	10,825	14,720			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,411,783	1,411,783		1,411,783	(531,788)	879,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,302	795	88,097		88,097		88,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			343,524	343,524		343,524		343,524			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		87,302	344,319	431,621		431,621		431,621			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,393,284	321,006	4,260,972	7,975,262		7,975,262	(832,118)	7,143,144			45

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	125,514	30		9
10	Interest and Other Investment Income	(1,616)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(639)	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	(100)	21		18
19	Entertainment		20		19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(900)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,474)	27		24
25	Fund Raising, Advertising and Promotional	(59,226)	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	(38,306)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,997)		$	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 Amount	2 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)	(827,121)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (827,121)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (832,118)		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 Yes	2 No	3 Amount	4 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

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (38,306)	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**	(38,306)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION **#** 0031823 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	(639)	0	0	0	0	0	0	0	0	0	0	(639)	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	1,307	0	0	0	0	0	0	0	0	1,307	5
6	Maintenance	0	0	11,229	7,801	0	0	0	0	0	0	0	19,030	6
7	Other (specify):*	0	0	240	0	814	0	0	0	0	0	0	1,054	7
8	**TOTAL General Services**	(639)	0	12,776	7,801	814	0	0	0	0	0	0	20,752	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	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(55,200)	0	167,936	0	0	0	0	0	0	0	112,736	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(900)	0	1,595	0	0	0	0	0	0	0	0	695	19
20	Fees, Subscriptions & Promotions	(60,476)	0	815	0	0	0	0	0	0	0	0	(59,661)	20
21	Clerical & General Office Expenses	(38,406)	(431,000)	65,785	10,174	0	0	0	0	0	0	0	(393,447)	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	3,023	0	0	0	0	0	0	0	0	3,023	24
25	Other Admin. Staff Transportation	0	0	82	0	0	0	0	0	0	0	0	82	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(28,474)	0	12,689	0	31,275	0	0	0	0	0	0	15,490	27
28	**TOTAL General Administration**	(128,256)	(486,200)	83,989	178,110	31,275	0	0	0	0	0	0	(321,082)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,895)	(486,200)	96,765	185,911	32,089	0	0	0	0	0	0	(300,330)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	125,514	0	3,301	0	0	0	0	0	0	0	0	128,815	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,616)	162,085	3,873	0	0	0	0	0	0	0	0	164,342	32
33	Real Estate Taxes	0	0	4,230	0	0	0	0	0	0	0	0	4,230	33
34	Rent-Facility & Grounds	0	(840,000)	0	0	0	0	0	0	0	0	0	(840,000)	34
35	Rent-Equipment & Vehicles	0	0	10,825	0	0	0	0	0	0	0	0	10,825	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	123,898	(677,915)	22,229	0	0	0	0	0	0	0	0	(531,788)	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	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,997)	(1,164,115)	118,994	185,911	32,089	0	0	0	0	0	0	(832,118)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 55,200	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (55,200)	1
2	V	21	BOOKKEEPING SERVICES	431,000	" " "			(431,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	840,000	16000 S WABASH LLC			(840,000)	7
8	V	32	INTEREST		" " "		162,085	162,085	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,326,200			$ 162,085	$ * (1,164,115)	14

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 1,307	$ 1,307	15
16	V	6	REPAIR & MAINT.		" " "		11,229	11,229	16
17	V	7	EMP BEN-GEN SERV		" " "		240	240	17
18	V	19	PROFESSIONAL FEES		" " "		1,595	1,595	18
19	V	20	DUES AND SUBSCRIPTION		" " "		815	815	19
20	V	21	CLERICAL & GENERAL		" " "		65,785	65,785	20
21	V	24	SEMINARS AND TRAVEL		" " "		3,023	3,023	21
22	V	25	AUTO EXPENSE		" " "		82	82	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		12,689	12,689	23
24	V	30	DEPRECIATION		" " "		3,301	3,301	24
25	V	32	INTEREST		" " "		3,873	3,873	25
26	V	33	REAL ESTATE TAXES		" " "		4,230	4,230	26
27	V	35	EQUIPMENT RENTAL		" " "		10,446	10,446	27
28	V	35	EQUIPMENT RENTAL		" " "		379	379	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			$			$ 118,994	$ * 118,994	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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 7,801	$ 7,801	15
16	V	17	ADMIN COMP - M MAUER		" " "		23,380	23,380	16
17	V	17	ADMIN COMP - M AARON		" " "		26,560	26,560	17
18	V	17	ADMIN COMP - F AARON		" " "		9,400	9,400	18
19	V	17	ADMIN COMP - D AARON		" " "		18,534	18,534	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" " "				20
21	V	17	ADMIN COMP - S HARAMARAS		" " "		18,467	18,467	21
22	V	17	ADMIN COMP - D KUFTA		" " "		20,208	20,208	22
23	V	17	ADMIN COMP - HOWARD ALTER		" " "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "		5,885	5,885	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" " "		24,457	24,457	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" " "		21,045	21,045	26
27	V	21	CLERICAL COMP - S AARON		" " "		9,988	9,988	27
28	V	21	CLERICAL COMP - E MARYLES		" " "		186	186	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			$			$ 185,911	$ * 185,911	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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 814	$ 814	15
16	V	27	EMP BEN - M MAUER		" " "		1,268	1,268	16
17	V	27	EMP BEN - M AARON		" " "		1,833	1,833	17
18	V	27	EMP BEN - F AARON		" " "		7,237	7,237	18
19	V	27	EMP BEN - D AARON		" " "		1,503	1,503	19
20	V	27	EMP BEN - S GOLDSTEIN		" " "				20
21	V	27	EMP BEN - S HARAMARAS		" " "		5,944	5,944	21
22	V	27	EMP BEN - D KUFTA		" " "		1,417	1,417	22
23	V	27	EMP BEN - HOWARD ALTER		" " "				23
24	V	27	EMP BEN - V DAVIS		" " "		1,011	1,011	24
25	V	27	EMP BEN - NON OWNER		" " "		6,555	6,555	25
26	V	27	EMP BEN - NON OWNER - CFO		" " "		2,635	2,635	26
27	V	27	EMP BEN - S AARON		" " "		1,856	1,856	27
28	V	27	EMP BEN - E MARYLES		" " "		16	16	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			$			$ 32,089	$ * 32,089	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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SUSAN STERN	4.	BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW	16000 S WABASH LIMITED PTRNSHP		BUILDING CO	1
2	ABRAHAM STERN	4.	GROSS POINTE MANOR LLC	NILES	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MAURICE AARON	29.6	OTTAWA PAVILION LTD	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	9.2	PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5	MIRIAM LATINIK	6.67	STERLING PAVILION LTD	STERLING				5
6	MARIKA NISSAN	3.33	WARREN PARK HEALTH AND LIVING CEN	CHICAGO				6
7	MARSHALL MAUER	6.67	WATERFRONT TERRACE INC	CHICAGO				7
8	FRANCES MAUER	6.67	WOODBRIDGE NURSING PAVILION LTD	CHICAGO				8
9	HOWARD GELLER	1.67	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				9
10	NOAH WOLF	1.67	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				10
11	SHARON AARON	.733	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				11
12	CHANA MAUER-RAY	7.92						12
13	DENNIS NEHMER	.733						13
14	DIANIA KUFTA	.733						14
15	ESTHER MARYLES	7.92						15
16	TJE 2000 TRUST-EVAN STERN	2.						16
17	HOWIE & SUSIE ALTER	1.47						17
18	TJE 2000 TRUST-JONATHAN STERN	2.						18
19	SYLVIA AARON	.29						19
20	SUE KOPLIN HARAMARAS	.73						20
21	THE 2000 TRUST-TODD STERN	2.						21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	6.67	176,620	4.68	9.35	SALARY	$ 23,380	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIV	29.60	173,440	5.31	10.62	SALARY	26,560	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATIV	9.20	37,600	9		SALARY	9,400	17-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	33,000	17-1	4
5	SHARON AARON	SHAREHOLDER	CLERICAL	0.73	75,398	4.68	11.69	SALARY	9,988	21-7	5
6	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.73	50,939	5.31	13.28	SALARY	7,801	6-7	6
7	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.73	131,962	6.64	13.28	SALARY	20,208	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	7.92	15,079	0.34	1.22	SALARY	186	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 130,523		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: 01/01/2012 Ending: 2/31/2012

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 [X] 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 STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	413,728	13	$ 11,773	$	45,935	$ 1,307	1
2	6	REPAIR & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	45,935	11,229	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	413,728	13	2,165		45,935	240	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		45,935	1,595	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	413,728	13	7,338		45,935	815	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	45,935	65,785	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		45,935	3,023	7
8	25	AUTO EXPENSE	PATIENT DAYS	413,728	13	736		45,935	82	8
9	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	413,728	13	114,290		45,935	12,689	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		45,935	3,301	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		45,935	3,873	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		45,935	4,230	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	94,085		45,935	10,446	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		45,935	379	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,071,756	$ 456,183		$ 118,994	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] 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 STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	$ 58,740	$ 58,740	5	$ 7,801	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	5	23,380	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	5	26,560	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	47,000	47,000	9	9,400	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	52,765	52,765	14	18,534	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	102,086	102,086			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	73,867	73,867	8	18,467	7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	152,170	152,170	7	20,208	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V I	WGHTD AVG HOURS	40	8	117,701	117,701	2	5,885	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	184,393	184,393	6	24,457	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	45	10	180,028	180,028	5	21,045	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	85,386	85,386	5	9,988	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	15,265	15,265	0	186	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,401	$ 1,481,401		$ 185,911	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] 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 STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	$ 6,127	$	5	$ 814	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,847		5	1,268	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	13,801		5	1,833	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	36,183		9	7,237	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,278		14	1,503	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,829				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	23,776		8	5,944	7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,672		7	1,417	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,076				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	20,219		2	1,011	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	49,423		6	6,555	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,545		5	2,635	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	15,870		5	1,856	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	1,340		0	16	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,986	$		$ 32,089	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CHASE BANK		X	MORTGAGE			$	$			$ 111,812	1
2	MB FINANCIAL		X	MORTGAGE	INTEREST	07/11/12	2,500,000	2,500,000	07/10/17	4.7500	50,139	2
3	MB FINANCIAL		X	CONSTRUCTION LOAN	INTEREST	07/11/12		295,125	07/10/17	4.2500	136	3
4	PHARMACY		X	AP FINANCING				46,026			3,286	4
5	INTERCOMPANY	X		WORKING CAPITAL							4,167	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				800,000			28,700	6
7	MB FINANCIAL		X	WORKING CAPITAL				62,219			6,186	7
8			X	INSURANCE FINANCING							1,056	8
9	TOTAL Facility Related						$ 2,500,000	$ 3,703,370			$ 205,482	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 3,703,370			$ 205,482	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

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

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 424,000	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.)		$ 439,041	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,041	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 444,000	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.		$ 459,041	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	334,384	8
	2008	334,698	9
	2009	403,650	10
	2010	415,216	11
	2011	439,041	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 439,041.27	$ 439,041.27
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 439,041.27	$ 439,041.27

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 01/01/2012 Ending: 12/31/2012

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	NURSING HOME			$ 408,821	1
2					2
3	TOTALS			$ 408,821	3

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1986	1976	$ 3,187,988	$	30	$ 106,266	$ 106,266	$ 2,444,118	4
5											5
6											6
7											7
8	RELATED PARTY				49,252	1,263		1,407	144	27,205	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		4,715	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	76	27	1,493	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	847	20	1,335	488	25,537	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	239	87	4,421	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		5,040	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		18,277	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		18,121	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		9,767	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604	41	39	41		689	17
18	ROOF REPAIR			1996	3,800	97	39	97		1,598	18
19	GAZEBO			1996	1,282	33	39	33		540	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		1,125	20
21	ROOF REPAIR			1996	7,000	180	39	180		2,925	21
22	HOT WATER TANK			1996	12,098	310	39	310		4,998	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	175	39	175		2,677	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,695	39	2,695		51,287	24
25	ROOFING			1997	45,500	1,167	39	1,167		17,848	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		1,850	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	679	39	679		10,374	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	86	39	86		1,240	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		2,197	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240	365	39	365		5,244	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		838	31
32	ROOF REPAIR			1998	8,750	224	39	224		3,222	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		8,310	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		1,981	34
35	COUNTER TOPS			1998	712	18	39	18		158	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT IMPROVEMENT	1998	$ 1,185	$ 31	39	$ 31	$	$ 429	37
38	NURSES STATION	1999	16,601	426	39	426		5,946	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		1,606	39
40	FIRE SYSTEM	1999	2,625	67	39	67		934	40
41	FLOOR TILE	1999	10,807	277	39	277		4,867	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		3,376	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		3,062	43
44	AIR CONDITIONING	1999	14,451	371	39	371		5,081	44
45	RAILINGS	1999	3,282	84	39	84		1,145	45
46	ROOF WORK	1999	4,500	115	39	115		1,529	46
47	NURSE STATION	2000	7,090	258	27.5	258		3,237	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		2,902	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		3,821	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		1,179	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		1,580	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	4,807	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		2,344	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		2,382	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		1,203	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		2,370	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		998	57
58	CONCRETE PAD	2002	1,662	69	15	111	42	1,164	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		269	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		1,368	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		2,095	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		785	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		728	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		2,755	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		1,176	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		5,853	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		4,178	67
68	AIR CONDITIONING	2004	664	24	27.5	24		203	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,856,498	$ 18,703		$ 125,947	$ 107,244	$ 2,753,167	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,856,498	$ 18,703		$ 125,947	$ 107,244	$ 2,753,167	1
2	WATER HEATER,VALVE & PUMPS	2004	6,594	240	27.5	240		2,030	2
3	FIRE DOORS	2004	769	28	27.5	28		237	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		2,073	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		2,865	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		395	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		514	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		672	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		762	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		665	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		8,411	11
12	LANDSCAPING	2006	10,250	683	15	683		4,440	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		232	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		1,524	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		310	15
16	REPAIR FENCE	2006	2,000	133	15	133		864	16
17	FIRE DOORS	2006	1,058	39	27.5	39		252	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		517	18
19	GAZEBO	2007	4,671	311	15	311		1,711	19
20	DISH NETWORK CABLING	2007	19,000	691	27.5	691		3,772	20
21	WALL AIR CONDITIONER	2007	3,374	123	27.5	123		671	21
22	SECURITY DOORS	2007	4,837	176	27.5	176		961	22
23	PARKING LOT PAVING	2007	4,492	163	27.5	163		890	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	83	27.5	83		453	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	140	27.5	140		764	25
26	CAMERA SYSTEM	2008	8,020	292	27.5	292		1,301	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350	85	27.5	85		379	27
28	WALLPAPER & PLASTERING	2008	14,140	514	27.5	514		2,292	28
29	AC/HEATER UNITS	2008	6,221	226	27.5	226		1,008	29
30	DOOR & FRAME	2008	2,113	77	27.5	77		343	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340	558	27.5	558		2,488	31
32	DISH NETWORK EQUIPMENT	2009	3,748	136	27.5	136		470	32
33	AC / HEAT WALL UNITS	2009	5,321	194	27.5	194		671	33
34	TOTAL (lines 1 thru 33)		$ 4,037,845	$ 26,398		$ 133,642	$ 107,244	$ 2,798,104	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,037,845	$ 26,398		$ 133,642	$ 107,244	$ 2,798,104	1
2	ELECTRICAL WORK	2009	33,206	1,207	27.5	1,207		4,174	2
3	SECURITY SYSTEM REPAIRS	2009	9,610	349	27.5	349		1,207	3
4	ROOF & GUTTER REPAIRS	2009	9,355	341	27.5	341		1,179	4
5	DOORS	2009	1,108	40	27.5	40		138	5
6	DRYWALL,WALLPAPER, PAINT	2009	41,872	1,523	27.5	1,523		5,267	6
7	PLUMBING REPAIRS	2009	13,689	498	27.5	498		1,722	7
8	TILE & CARPET	2009	25,956	944	27.5	944		3,265	8
9	LIGHT FIXTURES, WINDOW TREATMENTS	2009	206,165	7,496	27.5	7,496		25,925	9
10	SECURITY ALARM-NEW KEY & CONTROLS,CAMERA	2010	3,175	116	27.5	116		285	10
11	SECURITY SYSTEM-EGRESS DOOR,MONITOR,CAMERAS	2010	3,050	111	27.5	111		273	11
12	HOT WATER HEATER,TANK AND VALVES	2010	10,658	388	27.5	388		954	12
13	WALL AIR CONDITIONERS	2010	5,675	207	27.5	207		509	13
14	INSTALLED MODULATING MOTOR, BOILER PUMP MOTOI	2010	3,611	131	27.5	131		322	14
15	REPLACED 8 HEAT DETECTORS	2010	1,875	68	27.5	68		167	15
16	NEW GAS VALVES ON ROOFTOP UNIT, HEATING REPAIR	2010	3,000	109	27.5	109		268	16
17	WATER MIXING VALVE, DIETARY SHERFING & BRACKET	2010	1,828	65	27.5	65		160	17
18	HEAT/COOL UNITS	2011	6,170	224	27.5	224		327	18
19	DOORS	2011	6,838	249	27.5	249		363	19
20	FIRE DAMPER/SECURITY SYSTEM WORK	2011	7,432	270	27.5	270		394	20
21	BOILER/HOT WATER HEATER	2011	20,909	760	27.5	760		1,108	21
22	SCANNER	2011	21,943	798	27.5	798		1,164	22
23	AMP METER ON GENERATOR	2011	1,969	72	27.5	72		105	23
24	WALL SINK	2011	910	33	27.5	33		48	24
25	CONCRETE WORK	2011	3,784	138	27.5	138		201	25
26	ELECTRIC WORK	2012	4,315	72	27.5	72		72	26
27	HEATING & AIRCONDITIONING	2012	6,231	104	27.5	104		104	27
28	SECURITY SYSTEM WORK	2012	965	16	27.5	16		16	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,493,144	$ 42,727		$ 149,971	$ 107,244	$ 2,847,821	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 468,610	$ 7,589	$ 37,984	$ 30,395	10 YRS	$ 318,274	71
72	Current Year Purchases	27,331	16,399	1,367	(15,032)	10 YRS	1,367	72
73	Fully Depreciated Assets	439,251					439,251	73
74	RELATED PARTY	25,687	357	806	449		22,877	74
75	TOTALS	$ 960,879	$ 24,345	$ 40,157	$ 15,812		$ 781,769	75

D. Vehicle Costs. (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			$ 27,859	$ 1,681	$ 4,139	$ 2,458		$ 7,860	76
77										77
78										78
79										79
80	TOTALS			$ 27,859	$ 1,681	$ 4,139	$ 2,458		$ 7,860	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)	$ 5,890,703	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,753	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,267	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 125,514	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,637,450	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		$ 576,297	92
93			93
94			94
95		$ 576,297	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.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,895 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

* 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.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	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	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			795			795	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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 prescrpts				62,094		62,094	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUPPLIES, XRAY, RENTALS, LAB						25,208		25,208	13
14	TOTAL			$		$ 795	$ 87,302		$ 88,097	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: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 118,465	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 295,000)	944,290		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	163,514		6
7	Other Prepaid Expenses	7,732		7
8	Accounts Receivable (owners or related parties)	306,905		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,540,906	$	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	1,255,904		15
16	Equipment, at Historical Cost	978,276		16
17	Accumulated Depreciation (book methods)	(1,315,145)		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 (spe HOUSE	95,560		22
23	Other(specify): DEPOSIT	29,918		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,044,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,585,419	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 540,586	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	908,245		29
30	Accrued Salaries Payable	356,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,608		31
32	Accrued Real Estate Taxes(Sch.IX-B)	444,000		32
33	Accrued Interest Payable	2,114		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)**	$ 2,275,888	$	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)**	$ 2,275,888	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 309,531	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,585,419	$	48

*(See instructions.)

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 180,555	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 180,555	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	128,976	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)**	$ 128,976	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)**	$ 309,531	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,797,688	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,797,688	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,934	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 304,934	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***	1,616	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,616	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)**	$ 8,104,238	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,125,660	31
32	Health Care	3,151,448	32
33	General Administration	1,854,750	33
	B. Capital Expense		
34	Ownership	1,411,783	34
	C. Ancillary Expense		
35	Special Cost Centers	88,097	35
36	Provider Participation Fee	343,524	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,975,262	40
41	**Income before Income Taxes (line 30 minus line 40)****	128,976	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 128,976	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,708,063	44
45	Private Pay - Net Inpatient Revenue	210,395	45
46	Medicare - Net Inpatient Revenue	1,509,393	46
47	Other-(specify) HOSPICE	369,837	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,797,688	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,934	2,171	$ 107,594	$ 49.56	1
2	Assistant Director of Nursing	1,934	2,091	75,555	36.13	2
3	Registered Nurses	4,589	4,794	150,471	31.39	3
4	Licensed Practical Nurses	39,997	44,155	1,086,648	24.61	4
5	CNAs & Orderlies	82,665	90,242	1,011,300	11.21	5
6	CNA Trainees					6
7	Licensed Therapist	8,028	8,559	358,895	41.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,829	2,091	29,178	13.95	9
10	Activity Assistants	7,858	8,471	81,638	9.64	10
11	Social Service Workers	3,789	4,244	63,954	15.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,413	4,643	87,203	18.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,030	2,211	132,913	60.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,062	12,298	200,586	16.31	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	762	762	7,349	9.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,890	186,732	$ 3,393,284 *	$ 18.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,257	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,080	11-3	44
45	Social Service Consultant	E	4,410	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,747		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANN MARIE HARRINGTON	ADMINISTRATOR		$ 99,913
FRED AARON	ADMINISTRATIVE		33,000
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,913

B. Administrative - Other

Description	Amount
	$ 55,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 55,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		76,985
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 76,985

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,007
Unemployment Compensation Insurance	42,063
FICA Taxes	257,028
Employee Health Insurance	125,593
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	17,433
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 540,124

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	427
Health Care Worker Background Check	1,750
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	1,250
MARKETING/ADV/PROMO	59,226
LICENSES/DUES/SUBSCRIPTIONS	19,548
MGMT CO ALLOC	815
TRUST/FRANCHISE/CONTRIB/ETC	(1,250)
Less: Public Relations Expense	(0)
Non-allowable advertising	(59,226)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,540

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	3,023
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,023

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 $14,850**

(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. $ **22,485** 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. $ **343,524**
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.