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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 01/02/87

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 01/01/2014 to 12/31/2014 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) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2014 Ending: 12/31/2014

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	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,261	326	4,236	8,823	8
9	SNF/PED					9
10	ICF	27,999	1,889	1,868	31,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,260	2,215	6,104	40,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.12%

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 4,130

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary		1,709	595,312	597,021		597,021		597,021			1
2	Food Purchase		1,883		1,883		1,883	(716)	1,167			2
3	Housekeeping			185,589	185,589		185,589		185,589			3
4	Laundry		6,461	100,501	106,962		106,962		106,962			4
5	Heat and Other Utilities			136,256	136,256		136,256	1,058	137,314			5
6	Maintenance	90,297	46,008	26,027	162,332		162,332	12,587	174,919			6
7	Other (specify):*			13,994	13,994		13,994	856	14,850			7
8	**TOTAL General Services**	90,297	56,061	1,057,679	1,204,037		1,204,037	13,785	1,217,822			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,392,472	118,203	11,910	2,522,585		2,522,585		2,522,585			10
10a	Therapy	378,987	4,230		383,217		383,217		383,217			10a
11	Activities	111,800	14,977	2,132	128,909		128,909		128,909			11
12	Social Services	51,190		4,453	55,643		55,643		55,643			12
13	CNA Training											13
14	Program Transportation			520	520		520		520			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,934,449	137,410	25,015	3,096,874		3,096,874		3,096,874			16
	C. General Administration											
17	Administrative	134,863		46,200	181,063		181,063	95,486	276,549			17
18	Directors Fees											18
19	Professional Services			107,952	107,952		107,952	(19,960)	87,992			19
20	Dues, Fees, Subscriptions & Promotions			88,861	88,861		88,861	(42,279)	46,582			20
21	Clerical & General Office Expenses	211,842	23,264	490,470	725,576		725,576	(441,602)	283,974			21
22	Employee Benefits & Payroll Taxes			527,814	527,814		527,814		527,814			22
23	Inservice Training & Education			6,896	6,896		6,896		6,896			23
24	Travel and Seminar							966	966			24
25	Other Admin. Staff Transportation			9,909	9,909		9,909	3,471	13,380			25
26	Insurance-Prop.Liab.Malpractice			221,600	221,600		221,600	(1,200)	220,400			26
27	Other (specify):*			100,224	100,224		100,224	(57,542)	42,682			27
28	**TOTAL General Administration**	346,705	23,264	1,599,926	1,969,895		1,969,895	(462,660)	1,507,235			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,371,451	216,735	2,682,620	6,270,806		6,270,806	(448,875)	5,821,931			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: 01/01/2014** **Ending: 12/31/2014**

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	
	OUTSIDE DIETARY SERVICE		595,312	595,312
3	**HOUSEKEEPING**			
	OUTSIDE HOUSEKEEPING SERVICE		185,589	
				185,589
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,524	
	OUTSIDE LAUNDRY SERVICE		98,977	100,501
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,580	
	ELECTRICITY		63,871	
	WATER		27,211	
	CABLE TV - LOBBY		3,594	
				136,256
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		13,104	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,348	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,575	
	FIRE SERVICE		0	
				26,027
7	**OTHER**			
	SCAVENGER		13,994	
	SECURITY SERVICE		0	
				13,994
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	8,410	
	UTILIZATION REVIEW FEES	XVIII B __-2	3,500	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				11,910
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	2,132	
				2,132
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,453	
				4,453
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		520	
				520
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	46,200	46,200
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	51,222	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	56,730	
				107,952
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	44,068	
	EMPLOYEE WANT ADS	XIX F	15,060	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	17,088	
	LICENSES & PERMITS	XIX F	11,041	
	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	899	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	705	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				88,861
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		21,252	
	OUTSIDE CLERICAL SERVICES		434,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	24,967	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,051	
	MESSENGER SERVICE		0	
				490,470

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	256,886	
	UNEMPLOYMENT COMPENSATION	XIX D	35,717	
	WORKERS COMPENSATION INSURANC	XIX D	78,818	
	HOSPITALIZATION INSURANCE	XIX D	139,524	
	EMPLOYEE BENEFITS - OTHER	XIX D	16,869	
	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	
				527,814
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,896	
				6,896
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,909	
				9,909
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		221,600	
				221,600
27	**OTHER**			
	BAD DEBTS	VI 24	100,224	
				100,224

GRAND TOTAL COLUMN 3 OTHER **2,682,620**

WINDMILL NURSING PAVILION
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	1,883
LESS SALES TAX	(716)
NET FOOD	1,167
TOTAL PATIENT CENSUS	40,579
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	121,737
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	121,737
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	121,737
NET FOOD	1,167
DIVIDE TOTAL MEALS/YEAR	121,737
COST PER MEAL	0.01
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			102,421	102,421		102,421	146,399	248,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,958	69,958		69,958	164,130	234,088			32
33	Real Estate Taxes							496,836	496,836			33
34	Rent-Facility & Grounds			840,000	840,000		840,000	(840,000)				34
35	Rent-Equipment & Vehicles			4,903	4,903		4,903	9,775	14,678			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,017,282	1,017,282		1,017,282	(22,860)	994,422			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,123	12,779	131,902		131,902		131,902			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			303,947	303,947		303,947		303,947			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		119,123	316,726	435,849		435,849		435,849			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,371,451	335,858	4,016,628	7,723,937		7,723,937	(471,735)	7,252,202			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: 01/01/2014 Ending: 12/31/2014

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	93,900	30		9
10	Interest and Other Investment Income	(3,201)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(716)	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	(24,967)	21		18
19	Entertainment		20		19
20	Contributions	(899)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(21,313)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,224)	27		24
25	Fund Raising, Advertising and Promotional	(44,068)	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	(58,126)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,614)		$	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)	(312,121)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (312,121)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (471,735)		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

STATE OF ILLINOIS

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (58,126)	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**	(58,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(716)	0	0	0	0	0	0	0	0	0	0	(716)	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	1,058	0	0	0	0	0	0	0	0	1,058	5
6	Maintenance	0	0	6,292	6,295	0	0	0	0	0	0	0	12,587	6
7	Other (specify):*	0	0	203	0	653	0	0	0	0	0	0	856	7
8	**TOTAL General Services**	(716)	0	7,553	6,295	653	0	0	0	0	0	0	13,785	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	(46,200)	0	141,686	0	0	0	0	0	0	0	95,486	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,313)	0	1,353	0	0	0	0	0	0	0	0	(19,960)	19
20	Fees, Subscriptions & Promotions	(44,967)	0	2,688	0	0	0	0	0	0	0	0	(42,279)	20
21	Clerical & General Office Expenses	(83,093)	(434,200)	66,888	8,803	0	0	0	0	0	0	0	(441,602)	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	966	0	0	0	0	0	0	0	0	966	24
25	Other Admin. Staff Transportation	0	0	3,471	0	0	0	0	0	0	0	0	3,471	25
26	Insurance-Prop.Liab.Malpractice	0	0	(1,200)	0	0	0	0	0	0	0	0	(1,200)	26
27	Other (specify):*	(100,224)	0	11,886	0	30,796	0	0	0	0	0	0	(57,542)	27
28	**TOTAL General Administration**	(249,597)	(480,400)	86,052	150,489	30,796	0	0	0	0	0	0	(462,660)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(250,313)	(480,400)	93,605	156,784	31,449	0	0	0	0	0	0	(448,875)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION **#** 0031823 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	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)	
30	Depreciation	93,900	50,393	2,106	0	0	0	0	0	0	0	0	146,399	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,201)	165,524	1,807	0	0	0	0	0	0	0	0	164,130	32
33	Real Estate Taxes	0	493,215	3,621	0	0	0	0	0	0	0	0	496,836	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	9,775	0	0	0	0	0	0	0	0	9,775	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	90,699	(130,868)	17,309	0	0	0	0	0	0	0	0	(22,860)	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)**	(159,614)	(611,268)	110,914	156,784	31,449	0	0	0	0	0	0	(471,735)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 46,200	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (46,200)	1
2	V	21	BOOKKEEPING SERVICES	434,200	" " "			(434,200)	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		" " "		165,524	165,524	8
9	V	33	REAL ESTATE TAXES		" " "		493,215	493,215	9
10	V	30	DEPRECIATION				50,393	50,393	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,320,400			$ 709,132	$ * (611,268)	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: 01/01/2014 Ending: 12/31/2014

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%	$ 1,058	$ 1,058	15
16	V	6	REPAIR & MAINT.		" " "		6,292	6,292	16
17	V	7	EMP BEN-GEN SERV		" " "		203	203	17
18	V	19	PROFESSIONAL FEES		" " "		900	900	18
19	V	20	DUES AND SUBSCRIPTION		" " "		2,688	2,688	19
20	V	21	CLERICAL & GENERAL		" " "		66,888	66,888	20
21	V	24	SEMINARS AND TRAVEL		" " "		966	966	21
22	V	25	AUTO EXPENSE		" " "		3,471	3,471	22
23	V	26	INSURANCE		" " "		(1,200)	(1,200)	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" " "		11,886	11,886	24
25	V	30	DEPRECIATION		" " "		2,106	2,106	25
26	V	32	INTEREST		" " "		1,807	1,807	26
27	V	33	REAL ESTATE TAXES		" " "		3,621	3,621	27
28	V	19	REAL ESTATE TAX PROTEST FEES		" " "		453	453	28
29	V	35	AUTO RENTAL		" " "		9,703	9,703	29
30	V	35	EQUIPMENT RENTAL		" " "		72	72	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			$			$ 110,914	$ * 110,914	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: 01/01/2014 Ending: 12/31/2014

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%	$ 6,295	$ 6,295	15
16	V	17	ADMIN COMP - M MAUER		" " "		18,886	18,886	16
17	V	17	ADMIN COMP - M AARON		" " "		21,235	21,235	17
18	V	17	ADMIN COMP - F AARON		" " "		2,200	2,200	18
19	V	17	ADMIN COMP - D AARON		" " "		19,533	19,533	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" " "				20
21	V	17	ADMIN COMP - S HARAMARAS		" " "		19,184	19,184	21
22	V	17	ADMIN COMP - D KUFTA		" " "		15,954	15,954	22
23	V	17	ADMIN COMP - HOWARD ALTER		" " "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "		12,051	12,051	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" " "		13,759	13,759	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" " "		18,884	18,884	26
27	V	21	CLERICAL COMP - S AARON		" " "		8,231	8,231	27
28	V	21	CLERICAL COMP - E MARYLES		" " "		572	572	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			$			$ 156,784	$ * 156,784	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: 01/01/2014 Ending: 12/31/2014

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%	$ 653	$ 653	15
16	V	27	EMP BEN - M MAUER		" " "		1,086	1,086	16
17	V	27	EMP BEN - M AARON		" " "		1,529	1,529	17
18	V	27	EMP BEN - F AARON		" " "		7,526	7,526	18
19	V	27	EMP BEN - D AARON		" " "		1,591	1,591	19
20	V	27	EMP BEN - S GOLDSTEIN		" " "				20
21	V	27	EMP BEN - S HARAMARAS		" " "		6,459	6,459	21
22	V	27	EMP BEN - D KUFTA		" " "		1,142	1,142	22
23	V	27	EMP BEN - HOWARD ALTER		" " "				23
24	V	27	EMP BEN - V DAVIS		" " "		2,923	2,923	24
25	V	27	EMP BEN - NON OWNER		" " "		4,365	4,365	25
26	V	27	EMP BEN - NON OWNER - CFO		" " "		2,289	2,289	26
27	V	27	EMP BEN - S AARON		" " "		1,593	1,593	27
28	V	27	EMP BEN - E MARYLES		" " "		293	293	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			$			$ 31,449	$ * 31,449	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: 01/01/2014 Ending: 12/31/2014

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.	BRADLEY	BRADLEY	16000 S WABASH LIMITED PTRNSHP		BUILDING CO	1
2	ABRAHAM STERN	4.	BRIDGEVIEW HEALTH CARE CENTER	BRIDGEVIEW	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MAURICE AARON	29.6	GROSS POINTE MANOR LLC	NILES	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	9.2	OTTAWA PAVILION LTD	OTTAWA				4
5	MIRIAM LATINIK	6.67	PARK RIDGE CARE CENTER LTD	PARK RIDGE				5
6	MARIKA NISSAN	3.33	STERLING PAVILION LTD	STERLING				6
7	MARSHALL MAUER	6.67	WARREN PARK HEALTH AND LIVING CEN	CHICAGO				7
8	FRANCES MAUER	6.67	WATERFRONT TERRACE INC	CHICAGO				8
9	HOWARD GELLER	1.67	WOODBRIDGE NURSING PAVILION LTD	CHICAGO				9
10	NOAH WOLF	1.67	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11	SHARON AARON	.733	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	CHANA MAUER-RAY	7.92	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				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: 01/01/2014 Ending: 12/31/2014

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	SCHEDULE	3.78	7.55	SALARY	$ 18,886	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIV	29.60	ATTACHED	4.25	8.49	SALARY	21,235	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATIV	9.20		9		SALARY	35,000	17-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	2,200	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL	0.73		3.78		SALARY	82	21-7	5
6	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.73		4.25		SALARY	6,295	6-7	6
7	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.73		5.31	10.62	SALARY	15,954	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	7.92		0.26		SALARY	572	21-7	8
9	DANIEL AARON	RELATED PARTY	ADMINISTRATIVE			12.96	32.41	SALARY	19,533	21-7	9
10	SUE KOPLIN HARAMARAS	SHAREHOLDER	ADMINISTRATIV	0.73		7.5		SALARY	19,184	17-7	10
11											11
12											12
13								TOTAL	$ 138,941		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: 01/01/2014 Ending: 2/31/2014

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	452,396	14	$ 11,795	$	40,579	$ 1,058	1
2	6	REPAIR & MAINT.	PATIENT DAYS	452,396	14	70,149	38,885	40,579	6,292	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	452,396	14	2,266		40,579	203	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	14	10,039		40,579	900	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	452,396	14	29,965		40,579	2,688	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	14	745,706	528,878	40,579	66,888	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	14	10,766		40,579	966	7
8	25	AUTO EXPENSE	PATIENT DAYS	452,396	14	38,698		40,579	3,471	8
9	26	INSURANCE	PATIENT DAYS	452,396	14	(13,379)		40,579	(1,200)	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	452,396	14	132,506		40,579	11,886	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	14	23,478		40,579	2,106	11
12	32	INTEREST	PATIENT DAYS	452,396	14	20,148		40,579	1,807	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	14	40,366		40,579	3,621	13
14	19	REAL ESTATE TAX PROTEST FEI	PATIENT DAYS	452,396	14	5,056		40,579	453	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	14	108,178		40,579	9,703	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	14	802		40,579	72	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,236,539	$ 567,763		$ 110,914	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	9	$ 59,284	$ 59,284	4	$ 6,295	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	18,886	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	4	21,235	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	11,000	11,000	9	2,200	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271	13	19,533	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	103,196	103,196			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	76,737	76,737	8	19,184	7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	150,258	150,258	5	15,954	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	11	127,632	127,632	4	12,051	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	129,197	129,197	5	13,759	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	40	11	200,000	200,000	4	18,884	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	87,119	87,119	4	8,231	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	60,541	60,541	0	572	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,477,235	$ 1,477,235		$ 156,784	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	9	$ 6,150	$	4	$ 653	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	11,498		4	1,086	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,402		4	1,529	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,628		9	7,526	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,909		13	1,591	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,033				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,836		8	6,459	7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	10,754		5	1,142	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,085				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,956		4	2,923	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	40,985		5	4,365	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,244		4	2,289	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	16,859		4	1,593	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	30,999		0	293	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 293,338	$		$ 31,449	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	MB FINANCIAL		X	MORTGAGE	INTEREST	07/11/12	$ 2,500,000	$ 2,500,000	07/10/17	4.2500	$ 115,122	1
2	MB FINANCIAL		X	CONSTRUCTION LOAN	INTEREST	07/11/12		1,565,194	07/10/17	4.2500	50,402	2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				998,723			42,399	6
7	INTERCOMPANY	X		WORKING CAPITAL				1,220,529			27,559	7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 6,284,446			$ 235,482	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	$ 6,284,446			$ 235,482	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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 493,215	2
3. Under or (over) accrual (line 2 minus line 1).		$ 493,215	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 493,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	403,650	8
	2010	415,216	9
	2011	439,041	10
	2012	476,614	11
	2013	493,215	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 493,215.42	$ 493,215.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 493,215.42	$ 493,215.42

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	$ 2,656,650	4
5											5
6											6
7											7
8	RELATED PARTY				39,790	1,020	35	1,137	117	27,618	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		5,117	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	45	(4)	1,538	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	847	20		(847)	26,695	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	125	(27)	4,785	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		5,550	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		20,165	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		20,113	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		10,873	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604	41	39	41		771	17
18	ROOF REPAIR			1996	3,800	97	39	97		1,792	18
19	GAZEBO			1996	1,282	33	39	33		606	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		1,263	20
21	ROOF REPAIR			1996	7,000	180	39	180		3,285	21
22	HOT WATER TANK			1996	12,098	310	39	310		5,618	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	175	39	175		3,027	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,695	39	2,695		56,677	24
25	ROOFING			1997	45,500	1,167	39	1,167		20,182	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		2,092	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	679	39	679		11,732	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	86	39	86		1,412	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		2,503	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240	365	39	365		5,974	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		956	31
32	ROOF REPAIR			1998	8,750	224	39	224		3,670	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		9,464	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		2,257	34
35	COUNTER TOPS			1998	712	18	39	18		194	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: 01/01/2014 Ending: 12/31/2014

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	$	$ 491	37
38	NURSES STATION	1999	16,601	426	39	426		6,798	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		1,850	39
40	FIRE SYSTEM	1999	2,625	67	39	67		1,068	40
41	FLOOR TILE	1999	10,807	277	39	277		5,421	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		3,868	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		3,516	43
44	AIR CONDITIONING	1999	14,451	371	39	371		5,823	44
45	RAILINGS	1999	3,282	84	39	84		1,313	45
46	ROOF WORK	1999	4,500	115	39	115		1,759	46
47	NURSE STATION	2000	7,090	258	27.5	258		3,753	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		3,364	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		4,429	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		1,367	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		1,832	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	5,643	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		2,756	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		2,800	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		1,415	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		2,786	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		1,174	57
58	CONCRETE PAD	2002	1,662	69	15	111	42	1,386	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		321	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		1,638	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		2,499	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		951	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		882	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		3,337	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		1,454	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		7,237	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		5,166	67
68	AIR CONDITIONING	2004	664	24	27.5	24		251	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,847,036	$ 18,460		$ 124,197	$ 105,737	$ 3,000,927	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,847,036	$ 18,460		$ 124,197	$ 105,737	$ 3,000,927	1
2	WATER HEATER,VALVE & PUMPS	2004	6,594	240	27.5	240		2,510	2
3	FIRE DOORS	2004	769	28	27.5	28		293	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		2,629	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		3,633	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		501	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		652	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		880	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		998	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		871	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		10,999	11
12	LANDSCAPING	2006	10,250	683	15	683		5,806	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		304	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		1,996	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		406	15
16	REPAIR FENCE	2006	2,000	133	15	133		1,130	16
17	FIRE DOORS	2006	1,058	39	27.5	39		330	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		677	18
19	GAZEBO	2007	4,671	311	15	311		2,333	19
20	DISH NETWORK CABLING	2007	19,000	691	27.5	691		5,154	20
21	WALL AIR CONDITIONER	2007	3,374	123	27.5	123		917	21
22	SECURITY DOORS	2007	4,837	176	27.5	176		1,313	22
23	PARKING LOT PAVING	2007	4,492	163	27.5	163		1,216	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	83	27.5	83		619	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	140	27.5	140		1,044	25
26	CAMERA SYSTEM	2008	8,020	292	27.5	292		1,885	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350	85	27.5	85		549	27
28	WALLPAPER & PLASTERING	2008	14,140	514	27.5	514		3,320	28
29	AC/HEATER UNITS	2008	6,221	226	27.5	226		1,460	29
30	DOOR & FRAME	2008	2,113	77	27.5	77		497	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340	558	27.5	558		3,604	31
32	DISH NETWORK EQUIPMENT	2009	3,748	136	27.5	136		742	32
33	AC / HEAT WALL UNITS	2009	5,321	194	27.5	194		1,059	33
34	TOTAL (lines 1 thru 33)		$ 4,028,383	$ 26,155		$ 131,892	$ 105,737	$ 3,061,254	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: 01/01/2014 Ending: 12/31/2014

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		$ 4,028,383	$ 26,155		$ 131,892	$ 105,737	$ 3,061,254	1
2	ELECTRICAL WORK	2009	33,206	1,207	27.5	1,207		6,588	2
3	SECURITY SYSTEM REPAIRS	2009	9,610	349	27.5	349		1,905	3
4	ROOF & GUTTER REPAIRS	2009	9,355	341	27.5	341		1,861	4
5	DOORS	2009	1,108	40	27.5	40		218	5
6	DRYWALL,WALLPAPER, PAINT	2009	41,872	1,523	27.5	1,523		8,313	6
7	PLUMBING REPAIRS	2009	13,689	498	27.5	498		2,718	7
8	TILE & CARPET	2009	25,956	944	27.5	944		5,153	8
9	LIGHT FIXTURES, WINDOW TREATMENTS	2009	206,165	7,496	27.5	7,496		40,917	9
10	SECURITY ALARM-NEW KEY & CONTROLS,CAMERA	2010	3,175	116	27.5	116		517	10
11	SECURITY SYSTEM-EGRESS DOOR,MONITOR,CAMERAS	2010	3,050	111	27.5	111		495	11
12	HOT WATER HEATER,TANK AND VALVES	2010	10,658	388	27.5	388		1,730	12
13	WALL AIR CONDITIONERS	2010	5,675	207	27.5	207		923	13
14	INSTALLED MODULATING MOTOR, BOILER PUMP MOTOI	2010	3,611	131	27.5	131		584	14
15	REPLACED 8 HEAT DETECTORS	2010	1,875	68	27.5	68		303	15
16	NEW GAS VALVES ON ROOFTOP UNIT, HEATING REPAIR	2010	3,000	109	27.5	109		486	16
17	WATER MIXING VALVE, DIETARY SHERFING & BRACKET	2010	1,828	65	27.5	65		290	17
18	HEAT/COOL UNITS	2011	6,170	224	27.5	224		775	18
19	DOORS	2011	6,838	249	27.5	249		861	19
20	FIRE DAMPER/SECURITY SYSTEM WORK	2011	7,432	270	27.5	270		934	20
21	BOILER/HOT WATER HEATER	2011	20,909	760	27.5	760		2,628	21
22	SCANNER	2011	21,943	798	27.5	798		2,760	22
23	AMP METER ON GENERATOR	2011	1,969	72	27.5	72		249	23
24	WALL SINK	2011	910	33	27.5	33		114	24
25	CONCRETE WORK	2011	3,784	138	27.5	138		477	25
26	ELECTRIC WORK	2012	4,315	155	27.5	155		382	26
27	HEATING & AIRCONDITIONING	2012	6,231	226	27.5	226		556	27
28	SECURITY SYSTEM WORK	2012	965	38	27.5	38		92	28
29	GENERATOR INSTALL	2013	29,045	1,056	27.5	1,056		1,537	29
30	FIRE DOOR, ALARM SYSTEM, OPENERS, DOOR CURTAIN	2013	11,860	431	27.5	431		625	30
31	AIR CONDITIONERS	2013	6,025	219	27.5	219		316	31
32	LAUNDRY DUCT WORK, EXHAUST FAN	2013	3,886	141	27.5	141		206	32
33	PARKING LOT ASPHALT	2013	4,800	175	27.5	175		250	33
34	TOTAL (lines 1 thru 33)		$ 4,539,298	$ 44,733		$ 150,470	$ 105,737	$ 3,147,017	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: 01/01/2014 Ending: 12/31/2014

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 12C, Carried Forward		$ 4,539,298	$ 44,733		$ 150,470	$ 105,737	$ 3,147,017	1
2	ROOF REPAIR	2013	7,075	258	27.5	258		376	2
3	WIRING WRAP	2013	1,286	47	27.5	47		81	3
4	LED FLOOD LIGHTS	2013	580	21	27.5	21		33	4
5	RELATED PARTY - 16000 S WABASH LLC								5
6	1st FLOOR RESIDENT RMS-PAINT, PLASTER, FLOORING, LIGHTING,WARDROBES,ELECTRICAL,NURSE CALL SWITHCES								6
7		2013	229,186	8,334	27.5	8,334		16,668	7
8	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								8
9		2013	173,989	6,326	27.5	6,326		12,224	9
10	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								10
11		2013	12,775	465	27.5	465		930	11
12	SPRINKLER & FIRE ALARM INSTAL, REPAIR	2013	168,824	6,139	27.5	6,139		12,278	12
13	AC UNIT IN DINING ROOM	2013	3,830	139	27.5	139		278	13
14	SHOWER ROOM PLUMBING, NEW DRAINS	2013	6,595	240	27.5	240		480	14
15	THERAPY ROOM-DROP CEILING & LIGHTING	2013	5,367	195	27.5	195		390	15
16	ROOFTOP HEAT & AIR UNITS	2013	19,484	709	27.5	709		1,418	16
17	HALLWAYS-DOUBLE DOORS, ENTRY DOORS, WATER FOUNTAIN PLUMBING, TILE & GROUT, LIGHTING								17
18		2013	19,141	696	27.5	696		1,392	18
19	ASBESTOS REMOVAL- ONE WING, RESIDENT ROOMS	2013	64,345	2,340	27.5	2,340		4,680	19
20									20
21	1st & 2nd FLOOR RESIDENT RMS-PAINT, PLASTER, FLOORING, LIGHTING,WARDROBES,ELECTRICAL,NURSE CALL SWITHCES								21
22		2013	298,401	10,851	27.5	10,851		21,702	22
23	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								23
24		2013	122,981	4,472	27.5	4,472		8,944	24
25	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								25
26		2013	15,077	548	27.5	548		1,096	26
27	DINING ROOM WINDOW TREATMENTS SPRINKLER HEADS,WALL PROTECTOR								27
28		2013	32,844	1,194	27.5	1,194		2,388	28
29	TILE & GLASS BLOCK SHOWER ROOMS	2013	53,303	1,938	27.5	1,938		3,876	29
30	THERAPY ROOM WHIRLPOOL TUB & SPRINKLER HEADS	2013	9,087	330	27.5	330		660	30
31	HALLWAYS-HINGES & PROTECTION SYSTEM	2013	4,332	158	27.5	158		316	31
32	ASBESTOS REMOVAL- 2ND FLOOR RESIDENT ROOMS	2013	16,815	611	27.5	611		1,222	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,804,615	$ 90,744		$ 196,481	$ 105,737	$ 3,238,449	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: 01/01/2014 Ending: 12/31/2014

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 12D, Carried Forward		$ 5,804,615	$ 90,744		$ 196,481	$ 105,737	$ 3,238,449	1
2	OFFICES-ELECTRICAL WORK IN OFFICES AND								2
3	ROOM 210	2014	32,986	550	27.5	550		550	3
4	NEW OFFICE - CUBICLES INSTALL	2014	12,429	207	27.5	207		207	4
5	AIR CONDITIONERS	2014	3,166	53	27.5	53		53	5
6	NATURAL GAS GENERATOR REPLACEMENT; REMOVE AND								6
7	TRANSFER SWITCH FOR NEW GENERATOR	2014	33,922	565	27.5	565		565	7
8	ROOMS 101,102,103,104,201,202,203,204-LOCKER UNITS								8
9	INSTALLATION	2014	29,126	486	27.5	486		486	9
10	SPRINKLER SYSTEM REPAIR; INSTALLED FIRE SYSTEM	2014	4,429	74	27.5	74		74	10
11	SECURITY SYSTEM WORK: REPLACED CAMERA'S, PARTS,								11
12	MONITOR, DVD RECORDER, CABLE, PHONE	2014	13,094	218	27.5	218		218	12
13	PLUMBING WORK AND SUPPLIES: INSTALLED FLOOD								13
14	GARDS, EYEWASH STATION, REGULATORS INTO GAS LINE,								14
15	NEW PLUG IN CLEAN OUTS, FIXED SINKS & TALETS,								15
16	REPAIR POWER OUTAGE	2014	36,503	608	27.5	608		608	16
17	WALLCOVERING, WALL PLATE, DOOR, CARPET PAD	2014	2,843	47	27.5	47		47	17
18	NURSES STATION: INSTALL ANNUNCIATER	2014	1,797	30	27.5	30		30	18
19	FURNISH LABOR & MATERIAL TO INCREASE PRESSURE								19
20	TO 2 PSI	2014	2,139	36	27.5	36		36	20
21									21
22	RELATED PARTY-16000 S WABASH LLC								22
23	RESIDENTS ROOMS # 121,202,203,205,206,209,211,212,213,216,217,303,312,316,317- WALLPAPER, DRYWALL,PLASTER,FLOORING,SWITHCES,LI								23
24		2014	69,377	1,157	27.5	1,157		1,157	24
25	RESIDENTS BATHROOMS #203,213 ,COMMUNITY BATHROOM -PLUMBING,FINISH TRIM,MAKE BIGER SIZE								25
26		2014	14,488	241	27.5	241		241	26
27	DINING ROOM # 200-PAINT,DROP CEILING,DRYWALL,LIGHTING								27
28		2014	41,004	684	27.5	684		684	28
29	BEAUTY SHOP-FLOORING,WALLCOVERING,DRYWALL,VANITY, BOWL AND SINK								29
30		2014	14,068	235	27.5	235		235	30
31	LANDSCAPING RENOVATION/DESIGN-WIDEN THE EXISTING PAVER SIDEWALK,INSTALL NEW SHRUBS, PERENNIALS,SOD,STONE BORD								31
32		2014	20,147	1,344	15	1,344		1,344	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,136,133	$ 97,279		$ 203,016	$ 105,737	$ 3,244,984	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: 01/01/2014 Ending: 12/31/2014

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 12E, Carried Forward		$ 6,136,133	$ 97,279		$ 203,016	$ 105,737	$ 3,244,984	1
2	ROOF-RE-ROOFED PROPERTY USING DURO LAST ROOFING SYSTEMS,REPLACED 350 FEET OF WOOD, INSTALL 3 NEW SCUPPER DRAINS								2
3		2014	46,282	772	27.5	772		772	3
4	OFFICES/SOCIAL SERVICE WING-FLOORING,PAINT,PLASTER,WALLCOVERING,CUBICLES,CARPETING, DRYWALL, BUILD CLOSET								4
5		2014	16,495	275	27.5	275		275	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	TOTAL (lines 1 thru 33)		$ 6,198,910	$ 98,326		$ 204,063	$ 105,737	$ 3,246,031	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: 01/01/2014 Ending: 12/31/2014

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	$ 388,651	$ 10,235	$ 36,500	$ 26,265	10 YRS	$ 245,883	71
72	Current Year Purchases	75,454	45,273	3,773	(41,500)	10 YRS	3,773	72
73	Fully Depreciated Assets	587,732					587,732	73
74	RELATED PARTY	23,998	635	986	351		22,928	74
75	TOTALS	$ 1,075,835	$ 56,143	$ 41,259	$ (14,884)		$ 860,316	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				$ 21,141	$ 451	$ 3,498	$ 3,047		$ 14,781	76
77										77
78										78
79										79
80	TOTALS			$ 21,141	$ 451	$ 3,498	$ 3,047		$ 14,781	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)	$ 7,704,707	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,920	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 248,820	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 93,900	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,121,128	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.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,903 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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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			1,590			1,590	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				114,952		114,952	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,LAB					11,189	4,171		15,360	13
14	TOTAL			$		$ 12,779	$ 119,123		$ 131,902	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.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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 390,000)	1,210,373		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,243		6
7	Other Prepaid Expenses	6,499		7
8	Accounts Receivable (owners or related parties)	65,124		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,392,239	$	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	1,493,844		15
16	Equipment, at Historical Cost	1,093,971		16
17	Accumulated Depreciation (book methods)	(1,489,761)		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): DEPOSITS	31,598		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,129,652	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,521,891	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,930,643	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	998,723		29
30	Accrued Salaries Payable	247,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,259		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,177		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)**	$ 3,199,516	$	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)**	$ 3,199,516	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (677,625)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,521,891	$	48

***(See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (284,667)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (284,667)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(392,958)	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)**	$ (392,958)	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)**	$ (677,625)	24	*

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 7,329,031	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,329,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,385	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,385	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***	3,201	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,201	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,488,617	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,204,037	31
32	Health Care	3,096,874	32
33	General Administration	1,969,895	33
	B. Capital Expense		
34	Ownership	1,017,282	34
	C. Ancillary Expense		
35	Special Cost Centers	131,902	35
36	Provider Participation Fee	303,947	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	157,638	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,881,575	40
41	**Income before Income Taxes (line 30 minus line 40)****	(392,958)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (392,958)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,658,145	44
45	Private Pay - Net Inpatient Revenue	353,090	45
46	Medicare - Net Inpatient Revenue	2,026,392	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	291,404	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,329,031	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: 01/01/2014 Ending: 12/31/2014

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	2,029	2,246	$ 115,931	$ 51.62	1
2	Assistant Director of Nursing	1,905	2,118	74,859	35.34	2
3	Registered Nurses	5,637	6,039	185,831	30.77	3
4	Licensed Practical Nurses	35,801	40,111	1,017,271	25.36	4
5	CNAs & Orderlies	75,524	83,720	998,580	11.93	5
6	CNA Trainees					6
7	Licensed Therapist	8,377	8,797	378,987	43.08	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,719	2,022	29,305	14.49	9
10	Activity Assistants	7,054	7,927	82,495	10.41	10
11	Social Service Workers	2,241	2,374	51,190	21.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,270	4,391	90,297	20.56	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,013	2,286	134,863	59.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,435	16,135	211,842	13.13	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,005	178,166	$ 3,371,451 *	$ 18.92	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		$ 0	1-3	35
36	Medical Director	144	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	168	8,410	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	41	2,132	11-3	44
45	Social Service Consultant	56	4,453	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	409	$ 20,995		49

C. CONTRACT NURSES

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANN MARIE HARRINGTON	ADMINISTRATOR	0	$ 99,863
FRED AARON	ADMINISTRATIVE	9.2	35,000
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,863

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 46,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 46,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 107,952
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 107,952

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,818
Unemployment Compensation Insurance	35,717
FICA Taxes	256,886
Employee Health Insurance	139,524
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	16,869
TOTAL (agree to Schedule V, line 22, col.8)	$ 527,814

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	$ 1,990
Advertising: Employee Recruitment	15,060
Health Care Worker Background Check	705
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	899
MARKETING/ADV/PROMO	44,068
LICENSES/DUES/SUBSCRIPTIONS	26,139
MGMT CO ALLOC	2,688
TRUST/FRANCHISE/CONTRIB/ETC	(899)
Less: Public Relations Expense	(0)
Non-allowable advertising	(44,068)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,582

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOC	966
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 966

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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 $ 15,750**

(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. $ **27,090** 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. $ **303,947**
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.