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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 01/01/2017 to 12/31/2017 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: 01/01/2017 Ending: 12/31/2017

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			2,915	2,915	8
9	SNF/PED					9
10	ICF	37,913	969		38,882	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,913	969	2,915	41,797	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.34%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 1/02/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/2/1987 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 2,915

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		465	631,554	632,019		632,019		632,019			1
2	Food Purchase		828		828		828	(763)	65			2
3	Housekeeping		523		523		523		523			3
4	Laundry		7,998	111,908	119,906		119,906		119,906			4
5	Heat and Other Utilities			132,697	132,697		132,697	1,219	133,916			5
6	Maintenance	92,305	93,371	223,476	409,152		409,152	17,437	426,589			6
7	Other (specify):*			12,892	12,892		12,892	1,109	14,001			7
8	TOTAL General Services	92,305	103,185	1,112,527	1,308,017		1,308,017	19,002	1,327,019			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,528,298	149,791	50,965	2,729,054		2,729,054		2,729,054			10
10a	Therapy	522,366	5,166		527,532		527,532		527,532			10a
11	Activities	127,686	14,599	1,893	144,178		144,178		144,178			11
12	Social Services	52,330		6,208	58,538		58,538		58,538			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,230,680	169,556	65,066	3,465,302		3,465,302		3,465,302			16
	C. General Administration											
17	Administrative	103,444		19,200	122,644		122,644	225,981	348,625			17
18	Directors Fees											18
19	Professional Services			180,273	180,273		180,273	(10,270)	170,003			19
20	Dues, Fees, Subscriptions & Promotions			84,718	84,718		84,718	(39,740)	44,978			20
21	Clerical & General Office Expenses	243,638	26,052	370,636	640,326		640,326	(292,895)	347,431			21
22	Employee Benefits & Payroll Taxes			581,730	581,730		581,730		581,730			22
23	Inservice Training & Education			5,066	5,066		5,066		5,066			23
24	Travel and Seminar							408	408			24
25	Other Admin. Staff Transportation			7,003	7,003		7,003	3,703	10,706			25
26	Insurance-Prop.Liab.Malpractice			215,689	215,689		215,689	10,946	226,635			26
27	Other (specify):*	117,879		266,754	384,633		384,633	(171,405)	213,228			27
28	TOTAL General Administration	464,961	26,052	1,731,069	2,222,082		2,222,082	(273,272)	1,948,810			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,787,946	298,793	2,908,662	6,995,401		6,995,401	(254,270)	6,741,131			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: 01/01/2017** **Ending: 12/31/2017**

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		631,554	631,554
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,671	
	CONTRACTED LAUNDRY SERVICES		107,237	111,908
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		22,674	
	ELECTRICITY		66,591	
	WATER		40,413	
	CABLE TV - LOBBY		3,019	
				132,697
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,398	
	PAINTING & DECORATING		345	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,739	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,015	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINTENANCE		197,979	
				223,476
7	**OTHER**			
	SCAVENGER		12,892	
	SECURITY SERVICE		0	
				12,892
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	11,055	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	NURSING PROGRAM CONSULTANT		39,910	
				50,965
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 CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	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	1,893	
				1,893
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,208	
				6,208
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	19,200	19,200
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	101,896	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	78,377	
				180,273
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	44,130	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	1,124	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	23,609	
	LICENSES & PERMITS	XIX F	14,889	
	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	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	940	
	PATIENT BACKGROUND CHECKS	XIX F	26	
				84,718
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,637	
	EQUIPMENT REPAIR & MAINTENANCE		35,134	
	OUTSIDE CLERICAL SERVICES		300,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,430	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,235	
	MESSENGER SERVICE		0	
	ADMINISTRATIVE & MEETING FEES		4,200	370,636

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	286,325	
	UNEMPLOYMENT COMPENSATION	XIX D	27,441	
	WORKERS COMPENSATION INSURANC	XIX D	80,018	
	HOSPITALIZATION INSURANCE	XIX D	166,808	
	EMPLOYEE BENEFITS - OTHER	XIX D	21,138	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				581,730
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,066	
				5,066
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,003	
				7,003
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		215,689	
				215,689
27	**OTHER**			
	BAD DEBTS	VI 24	266,754	
				266,754

GRAND TOTAL COLUMN 3 OTHER **2,908,662**

WINDMILL NURSING PAVILION
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	828
LESS SALES TAX	(763)
NET FOOD	65
TOTAL PATIENT CENSUS	41,797
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	125,391
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	54,750
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	125,391
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	125,391
NET FOOD	65
DIVIDE TOTAL MEALS/YEAR	125,391
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			89,122	89,122		89,122	173,709	262,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			160,911	160,911		160,911	265,594	426,505			32
33	Real Estate Taxes							228,488	228,488			33
34	Rent-Facility & Grounds			850,000	850,000		850,000	(850,000)				34
35	Rent-Equipment & Vehicles			40,665	40,665		40,665	15,353	56,018			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,140,698	1,140,698		1,140,698	(166,856)	973,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,354		102,354		102,354		102,354			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,885	267,885		267,885		267,885			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		102,354	267,885	370,239		370,239		370,239			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,787,946	401,147	4,317,245	8,506,338		8,506,338	(421,126)	8,085,212			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: 01/01/2017 Ending: 12/31/2017

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	156,678	30		9
10	Interest and Other Investment Income	(5,818)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(763)	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	(1,430)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(11,286)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(266,754)	27		24
25	Fund Raising, Advertising and Promotional	(44,130)	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 SEE PG 5A	(114,742)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (288,245)		$	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)	(132,881)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (132,881)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (421,126)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (114,264)	21	1
2	MARKETING TRAVEL	(478)	25	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**	(114,742)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(763)	0	0	0	0	0	0	0	0	0	0	(763)	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	1,219	0	0	0	0	0	0	0	0	1,219	5
6	Maintenance	0	0	9,467	7,970	0	0	0	0	0	0	0	17,437	6
7	Other (specify):*	0	0	248	0	861	0	0	0	0	0	0	1,109	7
8	**TOTAL General Services**	(763)	0	10,934	7,970	861	0	0	0	0	0	0	19,002	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	(19,200)	0	245,181	0	0	0	0	0	0	0	225,981	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,286)	0	1,016	0	0	0	0	0	0	0	0	(10,270)	19
20	Fees, Subscriptions & Promotions	(44,130)	0	4,390	0	0	0	0	0	0	0	0	(39,740)	20
21	Clerical & General Office Expenses	(115,694)	(300,000)	113,567	9,232	0	0	0	0	0	0	0	(292,895)	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	408	0	0	0	0	0	0	0	0	408	24
25	Other Admin. Staff Transportation	(478)	0	4,181	0	0	0	0	0	0	0	0	3,703	25
26	Insurance-Prop.Liab.Malpractice	0	6,041	4,905	0	0	0	0	0	0	0	0	10,946	26
27	Other (specify):*	(266,754)	0	18,075	0	77,274	0	0	0	0	0	0	(171,405)	27
28	**TOTAL General Administration**	(438,342)	(313,159)	146,542	254,413	77,274	0	0	0	0	0	0	(273,272)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(439,105)	(313,159)	157,476	262,383	78,135	0	0	0	0	0	0	(254,270)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	156,678	13,607	3,424	0	0	0	0	0	0	0	0	173,709	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,818)	269,315	2,097	0	0	0	0	0	0	0	0	265,594	32
33	Real Estate Taxes	0	224,679	3,809	0	0	0	0	0	0	0	0	228,488	33
34	Rent-Facility & Grounds	0	(850,000)	0	0	0	0	0	0	0	0	0	(850,000)	34
35	Rent-Equipment & Vehicles	0	0	15,353	0	0	0	0	0	0	0	0	15,353	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	150,860	(342,399)	24,683	0	0	0	0	0	0	0	0	(166,856)	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)**	(288,245)	(655,558)	182,159	262,383	78,135	0	0	0	0	0	0	(421,126)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 19,200	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (19,200)	1
2	V	21	BOOKKEEPING SERVICES	300,000	" " "			(300,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	850,000	16000 S WABASH LLC			(850,000)	7
8	V	32	INTEREST		" " "		269,315	269,315	8
9	V	33	REAL ESTATE TAXES		" " "		224,679	224,679	9
10	V	30	DEPRECIATION		" " "		13,607	13,607	10
11	V	26	INSURANCE		" " "		6,041	6,041	11
12	V								12
13	V								13
14	Total			$ 1,169,200			$ 513,642	$ * (655,558)	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: 01/01/2017 Ending: 12/31/2017

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%	$ 1,219	$ 1,219	15
16	V	6	REPAIR & MAINT. - SALARIES		" " "		3,697	3,697	16
17	V	6	REPAIR & MAINT. - OTHER		" " "		5,770	5,770	17
18	V	7	EMP BEN-GEN SERV		" " "		248	248	18
19	V	19	PROFESSIONAL FEES		" " "		710	710	19
20	V	20	DUES AND SUBSCRIPTION		" " "		4,390	4,390	20
21	V	21	CLERICAL & GENERAL - SALARIES		" " "		81,010	81,010	21
22	V	21	CLERICAL & GENERAL - OTHER		" " "		32,557	32,557	22
23	V	24	SEMINARS AND TRAVEL		" " "		408	408	23
24	V	25	AUTO EXPENSE		" " "		4,181	4,181	24
25	V	26	INSURANCE		" " "		4,905	4,905	25
26	V	27	EMP. BEN. - GEN, ADMIN.		" " "		18,075	18,075	26
27	V	30	DEPRECIATION		" " "		3,424	3,424	27
28	V	32	INTEREST		" " "		2,097	2,097	28
29	V	33	REAL ESTATE TAXES		" " "		3,809	3,809	29
30	V	19	REAL ESTATE TAX PROTEST FEES		" " "		306	306	30
31	V	35	AUTO RENTAL				14,723	14,723	31
32	V	35	EQUIPMENT RENTAL				630	630	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 182,159	$ * 182,159	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: 01/01/2017 Ending: 12/31/2017

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%	$ 7,970	$ 7,970	15
16	V	17	ADMIN COMP - M MAUER		" " "		23,662	23,662	16
17	V	17	ADMIN COMP - M AARON		" " "		27,324	27,324	17
18	V	17	ADMIN COMP - F AARON		" " "		500	500	18
19	V	17	ADMIN COMP - D AARON		" " "		9,300	9,300	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" " "				20
21	V	17	ADMIN COMP - B FREIDMAN		" " "				21
22	V	17	ADMIN COMP - R AARON		" " "		61,541	61,541	22
23	V	17	ADMIN COMP - S HARAMARAS		" " "		23,970	23,970	23
24	V	17	ADMIN COMP - D KUFTA		" " "		20,168	20,168	24
25	V	17	ADMIN COMP - HOWARD ALTER		" " "				25
26	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "		15,831	15,831	26
27	V	17	ADMIN COMP - NON OWNER - A CASSATA		" " "				27
28	V	17	ADMIN COMP - NON OWNER - VAR		" " "		34,485	34,485	28
29	V	17	ADMIN COMP - NON OWNER - CFO		" " "		28,400	28,400	29
30	V	21	CLERICAL COMP - S AARON		" " "		9,173	9,173	30
31	V	21	CLERICAL COMP - E MARYLES		" " "		59	59	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 262,383	$ * 262,383	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: 01/01/2017 Ending: 12/31/2017

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%	$ 861	$ 861	15
16	V	27	EMP BEN - M MAUER		" " "		4,455	4,455	16
17	V	27	EMP BEN - M AARON		" " "		5,680	5,680	17
18	V	27	EMP BEN - F AARON		" " "		8,509	8,509	18
19	V	27	EMP BEN - D AARON		" " "		940	940	19
20	V	27	EMP BEN - S GOLDSTEIN		" " "				20
21	V	27	EMP BEN - B FREIDMAN		" " "				21
22	V	27	EMP BEN - R AARON		" " "		27,046	27,046	22
23	V	27	EMP BEN - S HARAMARAS		" " "		9,570	9,570	23
24	V	27	EMP BEN - D KUFTA		" " "		1,569	1,569	24
25	V	27	EMP BEN - HOWARD ALTER		" " "				25
26	V	27	EMP BEN - V DAVIS		" " "		4,246	4,246	26
27	V	27	EMP BEN - A CASSATA		" " "				27
28	V	27	EMP BEN - NON OWNER		" " "		9,366	9,366	28
29	V	27	EMP BEN - NON OWNER - CFO		" " "		3,281	3,281	29
30	V	27	EMP BEN - S AARON		" " "		2,192	2,192	30
31	V	27	EMP BEN - E MARYLES		" " "		420	420	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 78,135	$ * 78,135	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: 01/01/2017 Ending: 12/31/2017

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						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	ENFIELD 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: 01/01/2017 Ending: 12/31/2017

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	ADMINISTRATIVE		SCHEDULE	4.73	11.83	SALARY	$ 23,662	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIVE		ATTACHED	5.46	13.66	SALARY	27,324	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9		SALARY	42,000	21-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	500	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL			4.73	11.83	SALARY	9,173	17-7	5
6	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.46	13.66	SALARY	7,970	6-7	6
7	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIVE			5.46	13.66	SALARY	20,168	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.33	1.18	SALARY	59	21-7	8
9	DANIEL AARON	RELATED PARTY	ADMINISTRATIVE			4.86	12.15	SALARY	9,300	17-7	9
10	SUE KOPLIN HARAMARAS	SHAREHOLDER	ADMINISTRATIVE			10		SALARY	23,970	17-7	10
11	ROBERT AARON	RELATED PARTY	ADMINISTRATIVE			40		SALARY	61,541	17-7	11
12											12
13								TOTAL	$ 225,667		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: 01/01/2017 Ending: 2/31/2017

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	371,884	10	$ 10,844	$	41,797	$ 1,219	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	371,884	10	32,891	32,891	41,797	3,697	2
3	6	REPAIR & MAINT. - OTHER	PATIENT DAYS	371,884	10	51,340		41,797	5,770	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	371,884	10	2,209		41,797	248	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	10	6,316		41,797	710	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	371,884	10	39,064		41,797	4,390	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	371,884	10	720,780	720,780	41,797	81,010	7
8	21	CLERICAL & GENERAL - OTHER	PATIENT DAYS	371,884	10	289,675		41,797	32,557	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	10	3,633		41,797	408	9
10	25	AUTO EXPENSE	PATIENT DAYS	371,884	10	37,201		41,797	4,181	10
11	26	INSURANCE	PATIENT DAYS	371,884	10	43,644		41,797	4,905	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	371,884	10	160,819		41,797	18,075	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	10	30,466		41,797	3,424	13
14	32	INTEREST	PATIENT DAYS	371,884	10	18,656		41,797	2,097	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	10	33,889		41,797	3,809	15
16	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	371,884	10	2,725		41,797	306	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	10	130,997		41,797	14,723	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	10	5,607		41,797	630	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,620,756	$ 753,671		$ 182,159	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 58,337	$ 58,337	5	$ 7,970	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	23,662	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000	5	27,324	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500	9	500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	11	76,541	76,541	5	9,300	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	101,000	101,000			6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS							7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	61,541	61,541	40	61,541	8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	71,909	71,909	10	23,970	9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	147,753	147,753	5	20,168	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	9	133,816	133,816	5	15,831	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS							13
14	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	7	252,333	252,333	6	34,485	14
15	17	ADMIN COMP - NON OWNER - CF	WGHTD AVG HOURS	40	9	240,048	240,048	5	28,400	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	77,614	77,614	5	9,173	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	5,000	5,000	0	59	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,640,392	$ 1,640,392		$ 262,383	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 6,305	$	5	$ 861	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	37,655		5	4,455	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	7	41,575		5	5,680	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	42,544		9	8,509	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	11	7,737		5	940	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,621				6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS							7
8	27	EMP BEN - A CASSATA	WGHTD AVG HOURS	40	1	27,046		40	27,046	8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	28,711		10	9,570	9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	40	7	11,492		5	1,569	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,095				11
12	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	9	35,890		5	4,246	12
13	27	EMP BEN - A CASSATA	WGHTD AVG HOURS							13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	7	68,533		6	9,366	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	9	27,736		5	3,281	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	9	18,548		5	2,192	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	35,535		0	420	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 428,023	$		$ 78,135	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$27,748.05	7/1/12	$ 4,833,000	$ 4,448,486	10/10/20	4.2500	$ 230,287	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X		INTEREST ONLY		500,000	500,000	10/10/20	5.0000	6,337	6
7	MB FINANCIAL		X	WORKING CAPITAL				909,839			52,369	7
8	RELATED PARTY	X		WORKING CAPITAL				2,596,029			108,542	8
9	TOTAL Facility Related				$27,748.05		$ 5,333,000	$ 8,454,354			$ 397,535	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,333,000	$ 8,454,354			$ 397,535	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

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

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	463,000	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.)	$	471,597	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,597	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	477,000	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.	$	485,597	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	476,614	8
	2013	493,215	9
	2014	428,802	10
	2015	453,550	11
	2016	471,597	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 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 467,788.20	$ 467,788.20
2.			$	$
3.		RELATED PARTY	$ 3,809.00	$ 3,809.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 471,597.20	$ 471,597.20

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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	$ 2,975,448	4
5											5
6											6
7	RELATED PARTY				49,857			1,424	1,424	34,662	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334		31.5	201	201	5,720	9
10	LEASEHOLD IMPROVEMENT			1990	1,538		20			1,538	10
11	LEASEHOLD IMPROVEMENT			1991	26,695		20			26,695	11
12	LEASEHOLD IMPROVEMENT			1992	4,785		20			4,785	12
13	LEASEHOLD IMPROVEMENT			1993	8,024		31.5	255	255	6,315	13
14	LEASEHOLD IMPROVEMENT			1993	36,822		39	944	944	22,997	14
15	LEASEHOLD IMPROVEMENT			1994	38,826		39	996	996	23,101	15
16	LEASEHOLD IMPROVEMENT			1995	21,539		39	553	553	12,532	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604		39	41	41	894	17
18	ROOF REPAIR			1996	3,800		39	97	97	2,083	18
19	GAZEBO			1996	1,282		39	33	33	705	19
20	ASPHALT REMOVE & REPLACE			1996	2,686		39	69	69	1,470	20
21	ROOF REPAIR			1996	7,000		39	180	180	3,825	21
22	HOT WATER TANK			1996	12,098		39	310	310	6,548	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844		39	175	175	3,552	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092		39	2,695	2,695	64,762	24
25	ROOFING			1997	45,500		39	1,167	1,167	23,683	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721		39	121	121	2,455	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497		39	679	679	13,769	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359		39	86	86	1,670	28
29	DRAPES & INSTALLATION			1998	5,965		39	153	153	2,962	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240		39	365	365	7,069	30
31	EXHAUST FAN & INSTALLATION			1998	2,285		39	59	59	1,133	31
32	ROOF REPAIR			1998	8,750		39	224	224	4,342	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500		39	577	577	11,195	33
34	ELECTRICAL WORK			1998	5,376		39	138	138	2,671	34
35	COUNTER TOPS			1998	712		39	18	18	248	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: 01/01/2017 Ending: 12/31/2017

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	$	39	$ 31	$ 31	$ 584	37
38	NURSES STATION	1999	16,601		39	426	426	8,076	38
39	ALUMINUM WINDOWS	1999	4,740		39	122	122	2,216	39
40	FIRE SYSTEM	1999	2,625		39	67	67	1,269	40
41	FLOOR TILE	1999	10,807		39	277	277	6,252	41
42	DOOR AND MAGNET	1999	9,601		39	246	246	4,606	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850		39	227	227	4,197	43
44	AIR CONDITIONING	1999	14,451		39	371	371	6,936	44
45	RAILINGS	1999	3,282		39	84	84	1,565	45
46	ROOF WORK	1999	4,500		39	115	115	2,104	46
47	NURSE STATION	2000	7,090		27.5	258	258	4,527	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344		27.5	231	231	4,057	48
49	ROOF REPAIR	2000	8,378		27.5	304	304	5,341	49
50	PAVEMENT PATCH	2000	2,580		27.5	94	94	1,649	50
51	SMOKE DETECTOR	2000	3,473		27.5	126	126	2,210	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271		15			6,271	52
53	DOORS, DOOR RELEASE	2001	5,661		27.5	206	206	3,374	53
54	ROOF REPAIRS	2001	5,750		27.5	209	209	3,427	54
55	WALL AIRCONDITINER	2001	2,913		27.5	106	106	1,733	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720		27.5	208	208	3,410	56
57	SINK, SHELVES, CASES	2001	2,423		27.5	88	88	1,438	57
58	CONCRETE PAD	2002	1,662		15	54	54	1,662	58
59	ELECTRIC MOTOR	2002	714		27.5	26	26	399	59
60	WALL HEATER / AC	2002	3,705		27.5	135	135	2,043	60
61	ROOF REPAIRS	2002	5,550		27.5	202	202	3,105	61
62	WALL AIR CONDITIONER	2003	2,277		27.5	83	83	1,200	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116		27.5	77	77	1,113	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018		27.5	291	291	4,210	64
65	COMPRESSOR & CONDENSOR	2004	3,832		27.5	139	139	1,871	65
66	SHEET VINYL & COVE BASE	2004	19,015		27.5	692	692	9,313	66
67	ROOF REPAIRS	2004	13,586		27.5	494	494	6,648	67
68	AIR CONDITIONING	2004	664		27.5	24	24	323	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,857,103	$		$ 123,839	$ 123,839	$ 3,375,958	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: 01/01/2017 Ending: 12/31/2017

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		$ 3,857,103	$		$ 123,839	$ 123,839	$ 3,375,958	1
2	WATER HEATER,VALVE & PUMPS	2004	6,594		27.5	240	240	3,230	2
3	FIRE DOORS	2004	769		27.5	28	28	377	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659		27.5	278	278	3,463	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565		27.5	384	384	4,785	5
6	FIRE ALARM REPAIRS	2005	1,449		27.5	53	53	660	6
7	WALL AIR CONDITIONER	2005	1,892		27.5	69	69	859	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866		27.5	104	104	1,192	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240		27.5	118	118	1,352	9
10	WALL AIR CONDITIONER	2006	2,835		27.5	103	103	1,180	10
11	CONCRETE SIDEWALKS	2006	19,403		15	1,294	1,294	14,881	11
12	LANDSCAPING	2006	10,250		15	683	683	7,855	12
13	FREEZER COMPRESSOR	2006	1,000		27.5	36	36	412	13
14	SEWER, PIPE WORK, BOILER	2006	6,499		27.5	236	236	2,704	14
15	EXIT SIGNS	2006	1,316		27.5	48	48	550	15
16	REPAIR FENCE	2006	2,000		15	133	133	1,529	16
17	FIRE DOORS	2006	1,058		27.5	39	39	447	17
18	CONCRETE WORK	2006	2,200		27.5	80	80	917	18
19	GAZEBO	2007	4,671		15	311	311	3,266	19
20	DISH NETWORK CABLING	2007	19,000		27.5	691	691	7,227	20
21	WALL AIR CONDITIONER	2007	3,374		27.5	123	123	1,286	21
22	SECURITY DOORS	2007	4,837		27.5	176	176	1,841	22
23	PARKING LOT PAVING	2007	4,492		27.5	163	163	1,705	23
24	WATER SOFTENER, WATER HEATER	2007	2,288		27.5	83	83	868	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837		27.5	140	140	1,464	25
26	CAMERA SYSTEM	2008	8,020		27.5	292	292	2,761	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350		27.5	85	85	804	27
28	WALLPAPER & PLASTERING	2008	14,140		27.5	514	514	4,862	28
29	AC/HEATER UNITS	2008	6,221		27.5	226	226	2,138	29
30	DOOR & FRAME	2008	2,113		27.5	77	77	728	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340		27.5	558	558	5,278	31
32	DISH NETWORK EQUIPMENT	2009	3,748		27.5	136	136	1,150	32
33	AC / HEAT WALL UNITS	2009	5,321		27.5	194	194	1,641	33
34	TOTAL (lines 1 thru 33)		$ 4,038,450	$		$ 131,534	$ 131,534	$ 3,459,370	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: 01/01/2017 Ending: 12/31/2017

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		$ 4,038,450	$		$ 131,534	$ 131,534	$ 3,459,370	1
2	ELECTRICAL WORK	2009	33,206		27.5	1,207	1,207	10,209	2
3	SECURITY SYSTEM REPAIRS	2009	9,610		27.5	349	349	2,952	3
4	ROOF & GUTTER REPAIRS	2009	9,355		27.5	341	341	2,884	4
5	DOORS	2009	1,108		27.5	40	40	338	5
6	DRYWALL,WALLPAPER, PAINT	2009	41,872		27.5	1,523	1,523	12,882	6
7	PLUMBING REPAIRS	2009	13,689		27.5	498	498	4,212	7
8	TILE & CARPET	2009	25,956		27.5	944	944	7,985	8
9	LIGHT FIXTURES, WINDOW TREATMENTS	2009	206,165		27.5	7,496	7,496	63,405	9
10	SECURITY ALARM-NEW KEY & CONTROLS,CAMERA	2010	3,175		27.5	116	116	865	10
11	SECURITY SYSTEM-EGRESS DOOR,MONITOR,CAMERAS	2010	3,050		27.5	111	111	828	11
12	HOT WATER HEATER,TANK AND VALVES	2010	10,658		27.5	388	388	2,894	12
13	WALL AIR CONDITIONERS	2010	5,675		27.5	207	207	1,544	13
14	INSTALLED MODULATING MOTOR, BOILER PUMP MOTO	2010	3,611		27.5	131	131	977	14
15	REPLACED 8 HEAT DETECTORS	2010	1,875		27.5	68	68	507	15
16	NEW GAS VALVES ON ROOFTOP UNIT, HEATING REPAIR	2010	3,000		27.5	109	109	813	16
17	WATER MIXING VALVE, DIETARY SHERFING & BRACKET	2010	1,828		27.5	65	65	485	17
18	HEAT/COOL UNITS	2011	6,170		27.5	224	224	1,447	18
19	DOORS	2011	6,838		27.5	249	249	1,608	19
20	FIRE DAMPER/SECURITY SYSTEM WORK	2011	7,432		27.5	270	270	1,744	20
21	BOILER/HOT WATER HEATER	2011	20,909		27.5	760	760	4,908	21
22	SCANNER	2011	21,943		27.5	798	798	5,154	22
23	AMP METER ON GENERATOR	2011	1,969		27.5	72	72	465	23
24	WALL SINK	2011	910		27.5	33	33	213	24
25	CONCRETE WORK	2011	3,784		27.5	138	138	891	25
26	ELECTRIC WORK	2012	4,315		27.5	155	155	847	26
27	HEATING & AIRCONDITIONING	2012	6,231		27.5	226	226	1,234	27
28	SECURITY SYSTEM WORK	2012	965		27.5	38	38	206	28
29	GENERATOR INSTALL	2013	29,045		27.5	1,056	1,056	4,705	29
30	FIRE DOOR, ALARM SYSTEM, OPENERS, DOOR CURTAIN	2013	11,860		27.5	431	431	1,918	30
31	AIR CONDITIONERS	2013	6,025		27.5	219	219	973	31
32	LAUNDRY DUCT WORK, EXHAUST FAN	2013	3,886		27.5	141	141	629	32
33	PARKING LOT ASPHALT	2013	4,800		27.5	175	175	775	33
34	TOTAL (lines 1 thru 33)		$ 4,549,365	$		$ 150,112	$ 150,112	$ 3,600,867	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: 01/01/2017 Ending: 12/31/2017

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		$ 4,549,365	$		$ 150,112	$ 150,112	$ 3,600,867	1
2	ROOF REPAIR	2013	7,075		27.5	258	258	1,150	2
3	WIRING WRAP	2013	1,286		27.5	47	47	222	3
4	LED FLOOD LIGHTS	2013	580		27.5	21	21	122	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		27.5	8,334	8,334	41,670	7
8	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								8
9		2013	173,989		27.5	6,326	6,326	31,202	9
10	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								10
11		2013	12,775		27.5	465	465	2,325	11
12	SPRINKLER & FIRE ALARM INSTAL, REPAIR	2013	168,824		27.5	6,139	6,139	30,695	12
13	AC UNIT IN DINING ROOM	2013	3,830		27.5	139	139	695	13
14	SHOWER ROOM PLUMBING, NEW DRAINS	2013	6,595		27.5	240	240	1,200	14
15	THERAPY ROOM-DROP CEILING & LIGHTING	2013	5,367		27.5	195	195	975	15
16	ROOFTOP HEAT & AIR UNITS	2013	19,484		27.5	709	709	3,545	16
17	HALLWAYS-DOUBLE DOORS, ENTRY DOORS, WATER FOUNTAIN PLUMBING, TILE & GROUT, LIGHTING								17
18		2013	19,141		27.5	696	696	3,480	18
19	ASBESTOS REMOVAL- ONE WING, RESIDENT ROOMS	2013	64,345		27.5	2,340	2,340	11,700	19
20									20
21	1st & 2nd FLOOR RESIDENT RMS-PAINT, PLASTER, FLOORING, LIGHTING,WARDROBES,ELECTRICAL,NURSE CALL SWITHCES								21
22		2013	298,401		27.5	10,851	10,851	54,255	22
23	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								23
24		2013	122,981		27.5	4,472	4,472	22,360	24
25	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								25
26		2013	15,077		27.5	548	548	2,740	26
27	DINING ROOM WINDOW TREATMENTS SPRINKLER HEADS,WALL PROTECTOR								27
28		2013	32,844		27.5	1,194	1,194	5,970	28
29	TILE & GLASS BLOCK SHOWER ROOMS	2013	53,303		27.5	1,938	1,938	9,690	29
30	THERAPY ROOM WHIRLPOOL TUB & SPRINKLER HEADS	2013	9,087		27.5	330	330	1,650	30
31	HALLWAYS-HINGES & PROTECTION SYSTEM	2013	4,332		27.5	158	158	790	31
32	ASBESTOS REMOVAL- 2ND FLOOR RESIDENT ROOMS	2013	16,815		27.5	611	611	3,055	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,814,682	$		$ 196,123	$ 196,123	$ 3,830,358	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: 01/01/2017 Ending: 12/31/2017

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		$ 5,814,682	$		$ 196,123	$ 196,123	$ 3,830,358	1
2	OFFICES-ELECTRICAL WORK IN OFFICES AND								2
3	ROOM 210	2014	32,986		27.5	1,199	1,199	4,147	3
4	NEW OFFICE - CUBICLES INSTALL	2014	12,429		27.5	452	452	1,563	4
5	AIR CONDITIONERS	2014	3,166		27.5	115	115	398	5
6	NATURAL GAS GENERATOR REPLACEMENT; REMOVE AND								6
7	TRANSFER SWITCH FOR NEW GENERATOR	2014	33,922		27.5	1,234	1,234	4,267	7
8	ROOMS 101,102,103,104,201,202,203,204-LOCKER UNITS								8
9	INSTALLATION	2014	29,126		27.5	1,059	1,059	3,663	9
10	SPRINKLER SYSTEM REPAIR; INSTALLED FIRE SYSTEM	2014	4,429		27.5	161	161	557	10
11	SECURITY SYSTEM WORK: REPLACED CAMERA'S, PARTS,								11
12	MONITOR, DVD RECORDER, CABLE, PHONE	2014	13,094		27.5	476	476	1,646	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		27.5	1,327	1,327	4,589	16
17	WALLCOVERING, WALL PLATE, DOOR, CARPET PAD	2014	2,843		27.5	103	103	356	17
18	NURSES STATION: INSTALL ANNUNCIATER	2014	1,797		27.5	65	65	225	18
19	FURNISH LABOR & MATERIAL TO INCREASE PRESSURE								19
20	TO 2 PSI	2014	2,139		27.5	78	78	270	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,L								23
24		2014	69,377		27.5	2,523	2,523	8,726	24
25	RESIDENTS BATHROOMS #203,213 ,COMMUNITY BATHROOM -PLUMBING,FINISH TRIM,MAKE BIGER SIZE								25
26		2014	14,488		27.5	527	527	1,822	26
27	DINING ROOM # 200-PAINT,DROP CEILING,DRYWALL,LIGHTING								27
28		2014	41,004		27.5	1,491	1,491	5,157	28
29	BEAUTY SHOP-FLOORING,WALLCOVERING,DRYWALL,VANITY, BOWL AND SINK								29
30		2014	14,068		27.5	512	512	1,771	30
31	LANDSCAPING RENOVATION/DESIGN-WIDEN THE EXISTING PAVER SIDEWALK,INSTALL NEW SHRUBS, PERENNIALS,SOD,STONE BORI								31
32		2014	20,147		15	1,343	1,343	5,373	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,146,200	$		$ 208,788	$ 208,788	$ 3,874,888	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: 01/01/2017 Ending: 12/31/2017

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		$ 6,146,200	$		$ 208,788	$ 208,788	$ 3,874,888	1
2	ROOF-RE-ROOFED PROPERTY USING DURO LAST ROOFING SYSTEMS,REPLACED 350 FEET OF WOOD, INSTALL 3 NEW SCUPPER DRAIN								2
3		2014	46,282		27.5	1,683	1,683	5,821	3
4	OFFICES/SOCIAL SERVICE WING-FLOORING,PAINT,PLASTER,WALLCOVERING,CUBICLES,CARPETING, DRYWALL, BUILD CLOSET								4
5		2014	16,495		27.5	600	600	2,075	5
6	OFFICE-HUTCH,ELECTRICAL,WINDOW TREATMENTS,LIGHTING,PICTURES,WALLCOVERING								6
7		2015	9,332		39	261	261	642	7
8	WALL UNIT AC	2015	5,246		39	146	146	359	8
9	ELECTRICAL WORKFAMILY WAITING ROOM,BATH HOU	2015	19,576		39	546	546	1,343	9
10	FLAT SCREEN TV & MOUNTING BRACKET	2015	1,840		39	51	51	126	10
11	FLOORING,LIGHTING-DINING RM, CONFERENCE RM, SO	2015	7,171		39	200	200	492	11
12	FENCE	2015	1,475		39	41	41	101	12
13	FIRE DOORS, CAMERAS	2015	13,020		39	363	363	893	13
14	CONDENSER, KITCHEN HOOD FILTER RACK,PUMP	2015	13,331		39	372	372	915	14
15	PARKING LOT SEALED	2015	690		39	19	19	47	15
16	OUTDOOR SINAGE	2015	20,571		39	574	574	1,412	16
17	ASBESTOS ABATEMENT	2015	30,445		39	571	571	1,532	17
18	RESIDENT ROOM FLOORING,WALLPAPER,CORNER GUAI	2016	8,450		39	130	130	260	18
19	ARTWORK/MIRRORS/OVERBED LIGHTS	2016	1,637		39	28	28	56	19
20	THERAPY RM FLOORING,WALLPAPER,ELECTRICAL WOI	2016	45,399		39	540	540	1,080	20
21	LOBBY FLOORING/WALLPAPER	2016	2,743		39	35	35	70	21
22	DIALYSIS SUITE FLOORING,WALLPAPER,CORNER GUARI	2016	5,781		39	56	56	112	22
23	SINK	2016	689		39	12	12	24	23
24	WALL PIPE, AIR CONDITIONER,SPRINKLER WORK	2016	4,903		39	28	28	56	24
25	ACTIVITY ROOM DROP CEILING, WALLPAPER	2016	5,000		39	64	64	128	25
26	DINING ROOM WALLPAPER, DROP CEILING	2016	15,625		39	100	100	200	26
27	DOOR	2016	1,139		39	7	7	14	27
28	AC UNITS/GENERATOR	2017	9,109		39	117	117	117	28
29	DIALYSIS ROOM ELECTRICAL, FLOORING, PLUMBING	2017	55,132		39	2,827	2,827	2,827	29
30	THERAPY ROOM WINDOW TREATMENTS	2017	2,913		39	37	37	37	30
31	CONCRETE & PIPING IN BASEMENT	2017	5,480		39	70	70	70	31
32	NURSE CALL REPAIR	2017	3,440		39	44	44	44	32
33	3RD FLOOR RM FLOORING, LIGHTING, WALLS	2017	23,050		39	296	296	296	33
34	TOTAL (lines 1 thru 33)		$ 6,522,164	$		$ 218,606	$ 218,606	$ 3,896,037	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: 01/01/2017 Ending: 12/31/2017

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 12F, Carried Forward		$ 6,522,164	$		$ 218,606	$ 218,606	$ 3,896,037	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	BOOK DEPN			106,153			(106,153)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,522,164	$ 106,153		$ 218,606	$ 112,453	$ 3,896,037	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: 01/01/2017 Ending: 12/31/2017

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	$ 412,960	$	$ 39,094	$ 39,094	10	$ 222,096	71
72	Current Year Purchases	58,510		2,926	2,926	10	2,926	72
73	Fully Depreciated Assets	739,505					739,505	73
74	RELATED PARTY	30,070		805	805		28,689	74
75	TOTALS	$ 1,241,045	$	$ 42,825	$ 42,825		$ 993,216	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			$ 33,272	$	$ 1,400	$ 1,400		$ 26,490	76
77										77
78										78
79										79
80	TOTALS			$ 33,272	$	$ 1,400	$ 1,400		$ 26,490	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)	$ 8,205,302	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,153	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 262,831	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 156,678	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,915,743	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: 01/01/2017 Ending: 12/31/2017

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

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.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 40,665 Description:
(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: 01/01/2017 Ending: 12/31/2017

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.

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							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				88,000		88,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): Med Supplies, ECT	39-2					14,354		14,354	13
14	TOTAL			$		$	$ 102,354		$ 102,354	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: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 (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	$ 17,664	$ 1,337,046	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (455,000))	987,798	987,798	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,158	135,158	6
7	Other Prepaid Expenses	46,266	47,697	7
8	Accounts Receivable (owners or related parties)	65,332	41,861	8
9	Other(specify): RE TAX INFO		258,638	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,252,218	$ 2,808,198	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		510,924	13
14	Buildings, at Historical Cost		3,910,617	14
15	Leasehold Improvements, at Historical Cost	1,789,367	3,970,991	15
16	Equipment, at Historical Cost	1,254,062	1,319,062	16
17	Accumulated Depreciation (book methods)	(1,681,499)	(5,695,660)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		16,906	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(7,326)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	30,518	30,518	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,392,448	$ 4,056,032	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,644,666	$ 6,864,230	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 654,977	$ 654,977	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	909,839	909,839	29
30	Accrued Salaries Payable	316,520	316,520	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,178	14,178	31
32	Accrued Real Estate Taxes(Sch.IX-B)		477,000	32
33	Accrued Interest Payable	2,463	2,463	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY PAYABLE	2,596,029	2,596,029	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,494,006	$ 4,971,006	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		500,000	39
40	Mortgage Payable		4,448,486	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)**	$	$ 4,948,486	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,494,006	$ 9,919,492	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,849,340)	$ (3,055,262)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,644,666	$ 6,864,230	48

***(See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,049,853)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,049,853)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(799,487)	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) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (799,487)	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)**	$ (1,849,340)	24 *

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

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 7,746,180	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,746,180	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,827	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 133,827	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***	5,818	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,818	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)**	$ 7,885,825	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,308,017	31
32	Health Care	3,465,302	32
33	General Administration	2,222,082	33
	B. Capital Expense		
34	Ownership	1,140,698	34
	C. Ancillary Expense		
35	Special Cost Centers	102,354	35
36	Provider Participation Fee	267,885	36
	D. Other Expenses (specify):		
37	PRIOR YEAR ADJUSTMENT	178,974	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,685,312	40
41	**Income before Income Taxes (line 30 minus line 40)****	(799,487)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (799,487)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,848,737	44
45	Private Pay - Net Inpatient Revenue	98,541	45
46	Medicare - Net Inpatient Revenue	1,798,902	46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,746,180	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: 01/01/2017 Ending: 12/31/2017

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	2,129	1,687	$ 114,267	$ 67.73	1
2	Assistant Director of Nursing	1,751	1,523	69,004	45.31	2
3	Registered Nurses	13,697	13,025	460,899	35.39	3
4	Licensed Practical Nurses	28,076	25,793	736,591	28.56	4
5	CNAs & Orderlies	77,203	71,803	998,778	13.91	5
6	CNA Trainees					6
7	Licensed Therapist	8,725	8,267	367,215	44.42	7
8	Rehab/Therapy Aides	7,576	6,796	155,151	22.83	8
9	Activity Director	2,082	1,940	36,428	18.78	9
10	Activity Assistants	9,093	8,721	91,258	10.46	10
11	Social Service Workers	2,251	2,155	52,330	24.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,656	4,239	92,305	21.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,231	2,053	103,444	50.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,308	1,996	44,909	22.50	23
24	Clerical	6,924	6,323	198,729	31.43	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	539	539	10,957	20.33	31
32	Other Health C: Care Plan	4,504	4,090	137,802	33.69	32
33	Other(specify) Admitting,Social s	5,543	5,331	117,879	22.11	33
34	TOTAL (lines 1 - 33)	179,288	166,281	$ 3,787,946 *	$ 22.78	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	11,055	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,893	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,948		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: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNEMARIE HARRINGTON	ADMINISTRATOR		$ 103,444
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,444

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 19,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 19,200

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		180,273
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 180,273

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,018
Unemployment Compensation Insurance	27,441
FICA Taxes	286,325
Employee Health Insurance	166,808
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	21,138
TOTAL (agree to Schedule V, line 22, col.8)	$ 581,730

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,824
Advertising: Employee Recruitment	1,124
Health Care Worker Background Check	940
(Indicate # of checks performed)	
Patient Background Checks	26
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	44,130
LICENSES/DUES/SUBSCRIPTIONS	36,674
MGMT CO ALLOC	4,390
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(44,130)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,978

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
MGMT CO ALLOC	408
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 408

* Attach copy of IMRF notifications

**See instructions.

WINDMILL NURSING PAVILION
Legal Fee Schedule

DATE	NAME	DESCRIPTION	AMOUNT
2/1/2017	MUCH SHELIST	GENERAL COUNSELING	261.10
4/1/2017	MUCH SHELIST	GENERAL COUNSELING	154.00
7/1/2017	MUCH SHELIST	GENERAL COUNSELING	425.50
8/1/2017	MUCH SHELIST	GENERAL COUNSELING	500.50
9/1/2010	MUCH SHELIST	GENERAL COUNSELING	423.50
10/1/2017	MUCH SHELIST	GENERAL COUNSELING	89.09
11/1/2017	MUCH SHELIST	GENERAL COUNSELING	474.21
12/1/2017	MUCH SHELIST	GENERAL COUNSELING	350.00
1/1/2018	MUCH SHELIST	GENERAL COUNSELING	718.50
2/28/2017	SIMANDL LAW GROUP	FACILITY AUDITS	31.92
6/15/2017	VON BRIESEN & ROPER,S.C.	EMPLOYEE ARBITRATION	2,546.00
7/19/2017	VON BRIESEN & ROPER,S.C.	EMPLOYEE ARBITRATION	6,702.50
8/15/2017	VON BRIESEN & ROPER,S.C.	EMPLOYEE ARBITRATION	4,683.50
11/31/17	VON BRIESEN & ROPER,S.C.	LABOR AND EMPLOYMENT	1,600.50
12/31/2017	VON BRIESEN & ROPER,S.C.	EMPLOYEE ARBITRATION	61.00
1/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,118.45
1/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	22.50
1/31/2017	STONE POGRUND & KIREY	PEACE HOSPICE AND PALLIATIVE CARE	740.02
2/28/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	45.00
3/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	250.00
3/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	45.00
4/30/2017	STONE POGRUND & KIREY	PEACE HOSPICE AND PALLIATIVE CARE	50.00
5/31/2017	STONE POGRUND & KIREY	PEACE HOSPICE AND PALLIATIVE CARE	247.50
5/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,141.45
6/30/2016	STONE POGRUND & KIREY	PEACE HOSPICE AND PALLIATIVE CARE	300.00
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	634.77
7/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	425.80
7/31/2017	STONE POGRUND & KIREY	PEACE HOSPICE AND PALLIATIVE CARE	365.45
8/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,991.08
9/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	975.61
10/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	495.00
11/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,056.12
12/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	382.50
			30,308.07

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 $15,570**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(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. $ **42,634** 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. $ **267,885**
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) 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