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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0036533

Facility Name: Willow Crest Nursing Pavilion

Address: 515 North Main (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

HFS ID Number:

Date of Initial License for Current Owners: 01/11/1991

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: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	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	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	8	Intermediate (ICF)	8	2,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	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	7,107	3,782	5,565	16,454	8
9	SNF/PED					9
10	ICF	14,196	5,251	513	19,960	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,303	9,033	6,078	36,414	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.00%

D. How many bed-hold days during this year were paid by the Department?
None (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 08/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 4,972

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	222,260	22,370	9,480	254,110		254,110		254,110			1
2	Food Purchase		195,275		195,275	(20,312)	174,963	(481)	174,482			2
3	Housekeeping		16,533	139,501	156,034		156,034		156,034			3
4	Laundry		19,640	93,000	112,640		112,640		112,640			4
5	Heat and Other Utilities			124,075	124,075		124,075	1,246	125,321			5
6	Maintenance	39,621	79,170	61,977	180,768		180,768	51,960	232,728			6
7	Other (specify):*							624	624			7
8	**TOTAL General Services**	261,881	332,988	428,033	1,022,902	(20,312)	1,002,590	53,349	1,055,939			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,848,172	99,038	6,441	1,953,651		1,953,651	(2,482)	1,951,169			10
10a	Therapy		6,484		6,484		6,484		6,484			10a
11	Activities	88,993	13,215	1,275	103,483		103,483		103,483			11
12	Social Services	47,582		5,952	53,534		53,534		53,534			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,984,747	118,737	25,668	2,129,152		2,129,152	(2,482)	2,126,670			16
	C. General Administration											
17	Administrative	115,049			115,049		115,049	115,418	230,467			17
18	Directors Fees											18
19	Professional Services			490,082	490,082	(1,647)	488,435	(449,326)	39,109			19
20	Dues, Fees, Subscriptions & Promotions			68,580	68,580		68,580	(50,029)	18,551			20
21	Clerical & General Office Expenses	67,132	3,784	229,233	300,149		300,149	(133,297)	166,852			21
22	Employee Benefits & Payroll Taxes			565,841	565,841	20,312	586,153		586,153			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,499	13,499		13,499	(2,273)	11,226			24
25	Other Admin. Staff Transportation			8,794	8,794		8,794	664	9,458			25
26	Insurance-Prop.Liab.Malpractice			104,356	104,356		104,356	1,120	105,476			26
27	Other (specify):*							30,084	30,084			27
28	**TOTAL General Administration**	182,181	3,784	1,480,385	1,666,350	18,665	1,685,015	(487,639)	1,197,376			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,428,809	455,509	1,934,086	4,818,404	(1,647)	4,816,757	(436,772)	4,379,985			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Number Willow Crest Nursing Pavilion #0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			99,070	99,070		99,070	103,284	202,354			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,166	21,166		21,166	(10,522)	10,644			32
33	Real Estate Taxes			37,059	37,059	1,647	38,706	2,124	40,830			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			16,926	16,926		16,926	6,322	23,248			35
36	Other (specify):*											36
37	TOTAL Ownership			654,221	654,221	1,647	655,868	(378,792)	277,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	379,863	210,507	1,607	591,977		591,977	(1,660)	590,317			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	80,275			80,275		80,275	(80,275)				43
44	TOTAL Special Cost Centers	460,138	210,507	65,117	735,762		735,762	(81,935)	653,827			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,888,947	666,016	2,653,424	6,208,387	(0)	6,208,387	(897,499)	5,310,888			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Reference	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	35,319	30		9
10	Interest and Other Investment Income	(13,854)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(481)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,047)	21		18
19	Entertainment				19
20	Contributions	(1,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,000)	21		24
25	Fund Raising, Advertising and Promotional	(44,238)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(561)	20		28
29	Other-Attach Schedule	(80,958)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (281,420)		$	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)	(616,079)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (616,079)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (897,499)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (7,125)	21	1
2	COPE Dues	(4,303)	20	2
3	Non-allowable Legal	(10,740)	19	3
4	Prior Period - Medical/Nursing Supplies	(467)	10	4
5	Prior Period - Office Expenses	(8,291)	21	5
6	Prior Period - Radiology	(1,238)	39	6
7	2011 Seminar	(2,598)	24	7
8	Non-Allowable Travel	(57)	25	8
9	Additional R&M	44,088	06	9
10	Building Company - State Replacement Tax	(6,185)	21	10
11	Building Company - Accounting Fees	(950)	19	11
12	Building Compnay - Legal Fees	(250)	19	12
13	Marketing Salary	(80,275)	43	13
14	Capitalized R&M	(2,567)	06	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**	(80,958)		49

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(481)											(481)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,246									1,246	5
6	Maintenance	41,521		4,070	6,369								51,960	6
7	Other (specify):*					624							624	7
8	**TOTAL General Services**	41,040		5,316	6,369	624							53,349	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(467)					(2,015)						(2,482)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(467)					(2,015)						(2,482)	16
	C. General Administration													
17	Administrative				115,418								115,418	17
18	Directors Fees													18
19	Professional Services	(11,940)	1,200	(438,586)									(449,326)	19
20	Fees, Subscriptions & Promotions	(50,702)		673									(50,029)	20
21	Clerical & General Office Expenses	(196,648)	6,185	49,309	7,857								(133,297)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,598)		325									(2,273)	24
25	Other Admin. Staff Transportation	(57)		721									664	25
26	Insurance-Prop.Liab.Malpractice			1,120									1,120	26
27	Other (specify):*			9,568		20,516							30,084	27
28	**TOTAL General Administration**	(261,945)	7,385	(376,870)	123,275	20,516							(487,639)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(221,372)	7,385	(371,554)	129,644	21,140	(2,015)						(436,772)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	35,319	65,250	2,715									103,284	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,854)	(156)	3,488									(10,522)	32
33	Real Estate Taxes			2,124									2,124	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,322									6,322	35
36	Other (specify):*													36
37	**TOTAL Ownership**	21,465	(414,906)	14,649									(378,792)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,238)					(422)						(1,660)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(80,275)											(80,275)	43
44	**TOTAL Special Cost Centers**	(81,513)					(422)						(81,935)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(281,420)	(407,521)	(356,905)	129,644	21,140	(2,437)						(897,499)	45

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Willow Crest Building LLC		Building Co.

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	34	Rental Income	$ 480,000	Willow Crest Building Company	100.00%	$	$ (480,000)	1
2	V	32	Interest Income	156	Willow Crest Building Company	100.00%		(156)	2
3	V	21	State Replacement Tax		Willow Crest Building Company	100.00%	6,185	6,185	3
4	V	19	Accounting Fees		Willow Crest Building Company	100.00%	950	950	4
5	V	19	Legal Fees		Willow Crest Building Company	100.00%	250	250	5
6	V	30	Depreciation		Willow Crest Building Company	100.00%	65,250	65,250	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,156			$ 72,635	$ * (407,521)	14

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 CONS.	100.00%	$ 1,246	$ 1,246	15
16	V	6	REPAIRS & MAINT.				4,070	4,070	16
17	V	19	PROFESSIONAL FEES				754	754	17
18	V	20	DUES AND SUBSCRIPTIONS				673	673	18
19	V	21	CLERICAL & GENERAL				49,309	49,309	19
20	V	24	SEMINARS AND TRAVEL				325	325	20
21	V	25	AUTO EXP.				721	721	21
22	V	26	INSURANCE				1,120	1,120	22
23	V	27	EMP.BEN. - GEN. ADMIN.				9,568	9,568	23
24	V	30	DEPRECIATION				2,715	2,715	24
25	V	32	INTEREST				3,488	3,488	25
26	V	33	REAL ESTATE TAXES				2,124	2,124	26
27	V	35	EQUIPMENT RENTAL				6,322	6,322	27
28	V								28
29	V	19	Bookkeeping	439,340				(439,340)	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			$ 439,340			$ 82,435	$ * (356,905)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 6,369	$ 6,369	15
16	V	17	ADMIN. CMP. - M. MAUER				18,383	18,383	16
17	V	17	ADMIN. CMP. - M. AARON				20,845	20,845	17
18	V	17	ADMIN. CMP. - F. AARON				17,200	17,200	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN						19
20	V	17	ADMIN. CMP. - J. AARON						20
21	V	17	ADMIN. CMP. - S. KOPLIN						21
22	V	17	ADMIN. CMP. - D. MAGAFAS				16,841	16,841	22
23	V	17	ADMIN. CMP. - HOWARD ALTER						23
24	V	17	ADMIN. CMP. - NON-OWNER-V. DAVIS						24
25	V	17	ADMIN. CMP. - NON-OWNER -VAR.				23,763	23,763	25
26	V	17	ADMIN. CMP. - CFO NON OWNER				18,386	18,386	26
27	V	21	CLERICAL CMP. - S. AARON				7,857	7,857	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 129,644	$ * 129,644	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 CONS.	100.00%	$ 624	$ 624	15
16	V	27	EMP. BEN.- M. MAUER				1,000	1,000	16
17	V	27	EMP. BEN.- M. AARON				1,162	1,162	17
18	V	27	EMP. BEN.- F. AARON				7,113	7,113	18
19	V	27	EMP. BEN.- S. GOLDSTEIN						19
20	V	27	EMP. BEN.- J. AARON						20
21	V	27	EMP. BEN.- S. KOPLIN						21
22	V	27	EMP. BEN.- D. MAGAFAS				1,113	1,113	22
23	V	27	EMP. BEN.- HOWARD ALTER						23
24	V	27	EMP. BEN.-V. DAVIS						24
25	V	27	EMP. BEN.- NON-OWNER				6,780	6,780	25
26	V	27	EMP. BEN.- CFO NON-OWNER				1,975	1,975	26
27	V	27	EMP. BEN. - S. AARON				1,373	1,373	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 21,140	$ * 21,140	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$			$	$	15
16	V	10	MEDICAL SUPPLIES	17,411	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	15,396	(2,015)	16
17	V	39	ANCILLARY EXPENSE	3,647	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,225	(422)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,058			$ 18,621	$ * (2,437)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Sharon Aaron	Shareholder	Clerical	0.56	See Attached	3.68	9.20%	Alloc. Salary	$ 7,857	21-7	1
2	Fred Aaron	Shareholder	Administrative	13.10	See Attached	9	20.00%	Sal/Alloc. Sal	38,200	17-1; 17-7	2
3	Maurice Aaron	Shareholder	Administrative	23.79	See Attached	4.17	8.34%	Alloc. Salary	20,845	17-7	3
4	Marshall Mauer	Shareholder	Administrative	10.78	See Attached	3.68	7.36%	Alloc. Salary	18,383	17-7	4
5	Diania Kufta	Shareholder	Administrative	0.56	See Attached	5.21	10.42%	Alloc. Salary	16,841	17-7	5
6	Dennis Nehmer	Shareholder	Maintenance	0.56	See Attached	4.17	10.43%	Alloc. Salary	6,369	6-7	6
7											7
8	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered										8
9	Allowable By The IL. Dept of HFS										9
10											10
11											11
12											12
13								TOTAL	$ 108,495		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 Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 CONS.
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	400,612	11	$ 13,707	$	36,414	$ 1,246	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	400,612	11	44,776		36,414	4,070	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	400,612	11	8,291		36,414	754	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	400,612	11	7,402		36,414	673	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	400,612	11	542,482	382,381	36,414	49,309	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	400,612	11	3,581		36,414	325	6
7	25	AUTO EXP.	PATIENT DAYS	400,612	11	7,935		36,414	721	7
8	26	INSURANCE	PATIENT DAYS	400,612	11	12,320		36,414	1,120	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	400,612	11	105,262		36,414	9,568	9
10	30	DEPRECIATION	PATIENT DAYS	400,612	11	29,871		36,414	2,715	10
11	32	INTEREST	PATIENT DAYS	400,612	11	38,376		36,414	3,488	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	400,612	11	23,364		36,414	2,124	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	400,612	11	69,556		36,414	6,322	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 906,923	$ 382,381		$ 82,435	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 CONS.
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. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	61,112	61,112	4.17	6,369	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	3.68	18,383	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	4.17	20,845	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	86,000	86,000	9.00	17,200	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	89,700	89,700	-		5
6	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	40	1	3,386	3,386	-		6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	73,516	73,516	-		7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	161,659	161,659	5.21	16,841	8
9	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	1	74,483	74,483	-		10
11	17	ADMIN. CMP. - NON-OWNER -V	WGHTD. AVG. HOURS	45	8	228,000	228,000	4.69	23,763	11
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	200,022	200,022	4.14	18,386	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,429	85,429	3.68	7,857	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,475,307	$ 1,475,307		$ 129,644	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	5,988		4.17	624	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,884		3.68	1,000	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	11,145		4.17	1,162	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	35,563		9.00	7,113	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	35,796		-		5
6	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	40	1			-		6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,120		-		7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	10,687		5.21	1,113	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,083		-		9
10	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	1	16,762		-		10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	65,051		4.69	6,780	11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	21,483		4.14	1,975	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	14,927		3.68	1,373	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 254,489	$		$ 21,140	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: LINCOLN MEDICAL SUPPLIES, INC.
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										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						15,396	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						3,225	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 18,621	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				150,000			19,712	6
7	Insurance Financing		X	Insurance Financing							1,454	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 150,000			$ 21,166	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,854)	10
11	Interest Income - Bldg Co.		X								(156)	11
12	Allocated From Dyanamic	X									3,488	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (10,522)	14
15	TOTALS (line 9+line14)						$	$ 150,000			$ 10,644	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	42,000	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.)	$	41,183	2
3. Under or (over) accrual (line 2 minus line 1).	$	(817)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,000	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.**	$	1,647	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** $ 3,087 **For** 2008 **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.	$	40,830	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	47,064	8
2006	48,632	9
2007	48,033	10
2008	41,303	11
2009	39,059	12

2010 Accrual: $39,059 x 1.02 = $40,000 (Rounded)

Allocated From Dynamic HC Consultants: $2,124

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Long Term Care Property	$ 39,058.80	$ 39,058.80
2.	10-23-404-059-0000	Allocated From Dynamic	$ 31,304.03	$ 2,845.41
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,362.83	$ 41,904.21

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? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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 [X] (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).

None

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	Facility`		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	531	531	21,410	9
10	Various			1991	9,997		20			9,918	10
11	Various			1992	4,279		20	214	214	3,968	11
12	Various			1993	26,868		20	1,343	1,343	23,346	12
13	Various			1994	8,312		20	416	416	6,876	13
14	Various			1995	3,234		20	162	162	2,514	14
15	Various			1996	17,411		20	871	871	12,333	15
16	Various			1997	68,499		20	3,425	3,425	44,640	16
17	Various			1998	31,645		20	1,582	1,582	20,102	17
18	Various			1999	147,088		20	7,297	7,297	83,737	18
19	Various			2000	149,982		20	7,499	7,499	79,120	19
20	Various			2001	139,226		20	6,961	6,961	65,702	20
21	Various			2002	52,106		20	2,337	2,337	47,029	21
22	Various			2003	79,602		20	7,960	7,960	60,370	22
23	Various			2004	54,194		20	5,419	5,419	36,860	23
24	Various			2005	41,185		20	5,010	5,010	28,579	24
25	Various			2006	24,334		20	2,548	2,548	11,946	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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 Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,544,733	65,250		65,250		782,719	67
68	Related Party Allocations (Pages 12H & 12I)		40,321	1,034		1,152	118	19,969	68
69	Financial Statement Depreciation			99,070			(99,070)		69
70	TOTAL (lines 4 thru 69)		$ 3,464,425	$ 165,354		$ 119,977	$ (45,377)	$ 1,361,137	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,464,425	$ 165,354		$ 119,977	$ (45,377)	$ 1,361,137	1
2	Roof Repairs	2007	3,550		20	355	355	1,331	2
3	Heating And Ac Basement	2007	3,914		20	326	326	1,196	3
4	Roofing Materials	2007	5,678		20	568	568	2,035	4
5	Roofing Labor	2007	300		20	30	30	108	5
6	Roofing Labor	2007	300		20	30	30	108	6
7	Roofing Materials	2007	628		20	63	63	225	7
8	Roofing Labor	2007	1,050		20	105	105	376	8
9	Roofing Material	2007	2,733		20	273	273	979	9
10	2 A/C Heating Units	2007	3,926		20	327	327	1,145	10
11	Roofing Materials	2007	2,705		20	270	270	969	11
12	Roofing Labor	2007	2,750		20	275	275	985	12
13	Roofing Materials	2007	455		20	45	45	159	13
14	3 Fans	2007	510		20	102	102	357	14
15	Repair Water System	2007	2,600		20	260	260	910	15
16	2 Ac/Heating Units	2007	3,926		20	327	327	1,091	16
17	Fire And Sprinkler System	2007	4,997		20	714	714	2,261	17
18	3 Fire Alarms	2008	1,170		20	167	167	487	18
19	Dual Boiler System	2008	29,523		20	2,952	2,952	8,611	19
20	Alternator Energy Solution Generator Repairs	2008	1,480		20	148	148	370	20
21	Added Outdoor Lights	2008	3,350		20	335	335	838	21
22	Sprinkler Head Installation In Basement Laundry & First Floor L	2008	2,273		20	325	325	839	22
23	Upgraded Fire Alarm System	2008	14,529		20	2,076	2,076	5,189	23
24	Rebuilt Walk-In Cooler	2008	3,215		20	322	322	750	24
25	Fence	2008	855		20	86	86	192	25
26	Sidewalk Repair	2008	825		20	83	83	186	26
27	Air Conditioner Units	2008	4,141		20	828	828	1,794	27
28	Fire Alarm Systems	2008	1,190		20	238	238	516	28
29	Fire Alarm And Sprinkler Syst	2008	3,651		20	730	730	1,582	29
30	Bathroom Improvements	2008	7,490		20	749	749	1,623	30
31	Air Conditioner Units	2008	4,141		20	828	828	1,726	31
32	4 Heating Air Conditioning Units	2009	8,364		20	1,673	1,673	2,649	32
33	Roof Repair	2009	9,235		20	237	237	247	33
34	TOTAL (lines 1 thru 33)		$ 3,599,880	$ 165,354		$ 135,824	$ (29,530)	$ 1,402,969	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,599,880	$ 165,354		$ 135,824	$ (29,530)	$ 1,402,969	1
2	Electrical Work	2009	7,865		20	202	202	210	2
3	Air Conditioner	2009	6,898		20	1,380	1,380	1,495	3
4	Shower Room - Tiles	2010	5,882		20	145	145	145	4
5	Shower Room - Flooring, Walls, Tiles	2010	10,500		20	236	236	236	5
6	Plumbing In Shower Room	2010	9,300		20	209	209	209	6
7	Lights Work	2010	2,979		20	54	54	54	7
8	Therapy Room Remodel-Flooring, Walls, Ceiling	2010	3,519		20	26	26	26	8
9	Therapy Room Remodel-Flooring, Walls, Ceiling	2010	2,656		20	20	20	20	9
10	Upgrade Of Ac Units	2010	3,381		20	25	25	25	10
11	Oak Door	2010	3,407		20	85	85	85	11
12	Kitchen Cabinetry	2010	7,454		20	124	124	124	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)		$ 3,663,721	$ 165,354		$ 138,329	$ (27,025)	$ 1,405,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,663,721	$ 165,354		$ 138,329	$ (27,025)	$ 1,405,598	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
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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)		$ 3,663,721	$ 165,354		$ 138,329	$ (27,025)	$ 1,405,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,663,721	$ 165,354		$ 138,329	$ (27,025)	$ 1,405,598	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
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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)		$ 3,663,721	$ 165,354		$ 138,329	$ (27,025)	$ 1,405,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information								1
2	Buildings:								2
3	116 Beds	1975	2,544,733	65,250	39	65,250		782,719	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 (12F & 12G lines 1 thru 33)		$ 2,544,733	$ 65,250		$ 65,250	$	$ 782,719	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Dynamic	1993	40,321	1,034	35	1,152	118	19,969	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 (12H & 12I lines 1 thru 33)		$ 40,321	$ 1,034		$ 1,152	$ 118	$ 19,969	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 488,111	$	$ 48,018	$ 48,018	10	$ 402,224	71
72	Current Year Purchases	22,002		3,157	3,157	10	3,157	72
73	Fully Depreciated Assets	694,581		77	77	10	694,492	73
74								74
75	TOTALS	$ 1,204,695	$	$ 51,252	$ 51,252		$ 1,099,874	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2004	$ 44,500	$	$ 6,357	$ 6,357	5	$ 40,262	76
77		Used Van	2005	16,080		1,959	1,959	5	12,407	77
78		Allocated From Dynamic	2010	20,923	1,681	4,457	2,776	5	6,420	78
79										79
80	TOTALS			$ 81,503	$ 1,681	$ 12,773	$ 11,092		$ 59,089	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,277,778	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 167,035	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 202,354	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,319	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,564,560	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 Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 16,981 Description: See Attached Schedule
(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	Allocated From Dynamic		$	$ 6,267	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,267	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - 01	hrs	$ 179,093		$	$		$ 179,093	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	13,838					13,838	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	186,932					186,932	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				167,187		167,187	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,607	43,320		44,927	13
14	TOTAL			$ 379,863		$ 1,607	$ 210,507		$ 591,977	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 2,087	$ 155,130	1
2	Cash-Patient Deposits	12,634	12,634	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	590,336	590,336	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,092	106,092	6
7	Other Prepaid Expenses	2,955	2,955	7
8	Accounts Receivable (owners or related parties)		120,800	8
9	Other(specify): See Attached Schedule	168,366	168,366	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 882,470	$ 1,156,313	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	1,054,770	1,054,770	15
16	Equipment, at Historical Cost	876,775	1,282,775	16
17	Accumulated Depreciation (book methods)	(1,215,515)	(2,407,234)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		15,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 716,030	$ 2,817,903	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,598,500	$ 3,974,216	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 445,732	$ 445,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,194	21,194	28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	198,309	198,309	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,305	4,305	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	257	257	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,961	7,961	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	25,000	118,324	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 892,758	$ 986,082	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	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 892,758	$ 986,082	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 705,742	$ 2,988,134	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,598,500	$ 3,974,216	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 630,006	1
2	Restatements (describe):		2
3	Rounding Adjustment	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 630,003	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	75,739	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)**	$ 75,739	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)**	$ 705,742	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,884,801	1
2	Discounts and Allowances for all Levels	(1,622,018)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,262,783	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,549,650	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,549,650	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	250,296	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,003	19
20	Radiology and X-Ray	9,845	20
21	Other Medical Services	46,608	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 342,752	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,854	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,854	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	115,087	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 115,087	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,284,126	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,022,902	31
32	Health Care	2,129,152	32
33	General Administration	1,666,350	33
	B. Capital Expense		
34	Ownership	654,221	34
	C. Ancillary Expense		
35	Special Cost Centers	672,252	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,208,387	40
41	**Income before Income Taxes (line 30 minus line 40)****	75,739	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 75,739	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2,699	2,872	$ 103,265	$ 35.96	1
2	Assistant Director of Nursing	12	14	482	34.43	2
3	Registered Nurses	15,103	15,953	471,183	29.54	3
4	Licensed Practical Nurses	13,519	14,774	388,409	26.29	4
5	CNAs & Orderlies	69,889	73,887	835,662	11.31	5
6	CNA Trainees					6
7	Licensed Therapist	9,802	10,666	379,863	35.61	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	2,094	42,776	20.43	9
10	Activity Assistants	5,163	5,351	46,217	8.64	10
11	Social Service Workers	2,082	2,181	25,602	11.74	11
12	Dietician					12
13	Food Service Supervisor	2,074	2,150	42,994	20.00	13
14	Head Cook	3,861	4,012	42,361	10.56	14
15	Cook Helpers/Assistants	13,626	14,790	136,905	9.26	15
16	Dishwashers					16
17	Maintenance Workers	2,102	2,149	39,621	18.44	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,888	2,127	94,049	44.22	20
21	Assistant Administrator					21
22	Other Administrative	606	606	21,000	34.65	22
23	Office Manager					23
24	Clerical	4,008	4,467	67,132	15.03	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	2,394	2,754	49,171	17.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,350	4,438	102,255	23.04	33
34	TOTAL (lines 1 - 33)	155,016	165,285	$ 2,888,947 *	$ 17.48	34

SEE ACCOUNTANTS' COMPILATION REPORT

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	218	$ 9,480	01-03	35
36	Medical Director	240	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	161	6,441	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,275	11-03	44
45	Social Service Consultant	99	5,952	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	744	$ 35,148		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Ingold	Administrator	0.00%	$ 94,049
Fred Aaron	Administrative	13.10%	21,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 115,049

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 11,246
Health Data Systems	Data Processing	8,739
Casamba	Data Processing	3,600
E-Health Data Systems	Data Processing	300
Dynamic HC Consultants	Bookkeeepig	439,340
See Attached	Legal	13,999
Adj. on Page 5a	Legal	9,852
Personnel Planners	Unemployment Consult	1,218
Bradley & Bradley, Inc.	Architect Fees	141
Skidelsky & Associates	Real Estate Assesment	1,647
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 490,082

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 181,870
Unemployment Compensation Insurance	32,619
FICA Taxes	210,225
Employee Health Insurance	126,088
Employee Meals	20,312
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	15,039
TOTAL (agree to Schedule V, line 22, col.8)	$ 586,153

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	$
Advertising: Employee Recruitment	4,402
Health Care Worker Background Check	3,940
(Indicate # of checks performed 394)	
Patient Background Checks	
Advertising & Promotion	44,799
Licesnses and Permits	2,399
Dues and Subscriptions	7,137
Allocated From Dynamic	673
Less: Public Relations Expense	( )
Non-allowable advertising	(44,238)
Yellow page advertising	(561)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,551

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,901
Allocated From Dynamic	325
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,226

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC $8,839; IL Assoc of HC Facilities $1,296**

(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? **N/A**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **344** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **63,510**
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. $ **20,312** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
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? **No**
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: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.