FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0036533

Facility Name: Willow Crest Nrsing 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: 1/11/1991

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	4,433	1,614	5,134	11,181	8
9	SNF/PED					9
10	ICF	16,695	5,821	1,214	23,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,128	7,435	6,348	34,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.45%

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 5,161

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

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		1,612	394,317	395,929		395,929		395,929			1
2	Food Purchase		126,346		126,346	(13,542)	112,805	(266)	112,539			2
3	Housekeeping		565	162,834	163,399		163,399		163,399			3
4	Laundry		5,392	101,610	107,002		107,002		107,002			4
5	Heat and Other Utilities			125,695	125,695		125,695	910	126,605			5
6	Maintenance	55,892	42,029	68,464	166,385		166,385	27,635	194,020			6
7	Other (specify):*							737	737			7
8	TOTAL General Services	55,892	175,944	852,920	1,084,756	(13,542)	1,071,215	29,016	1,100,231			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,031,354	117,837	7,187	2,156,378		2,156,378		2,156,378			10
10a	Therapy		5,727		5,727		5,727		5,727			10a
11	Activities	144,973	17,465	1,677	164,115		164,115		164,115			11
12	Social Services	119,737		4,448	124,185		124,185		124,185			12
13	CNA Training											13
14	Program Transportation			101	101		101		101			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,296,064	141,029	25,413	2,462,506		2,462,506		2,462,506			16
	C. General Administration											
17	Administrative	138,402			138,402		138,402	105,722	244,124			17
18	Directors Fees											18
19	Professional Services			540,869	540,869	(390)	540,479	(464,345)	76,134			19
20	Dues, Fees, Subscriptions & Promotions			94,535	94,535		94,535	(51,796)	42,739			20
21	Clerical & General Office Expenses	35,172	4,807	404,773	444,752		444,752	(285,722)	159,030			21
22	Employee Benefits & Payroll Taxes			521,127	521,127	13,542	534,669		534,669			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,876	5,876		5,876	831	6,707			24
25	Other Admin. Staff Transportation			19,815	19,815		19,815	2,986	22,801			25
26	Insurance-Prop.Liab.Malpractice			122,768	122,768		122,768	2,971	125,739			26
27	Other (specify):*							32,219	32,219			27
28	TOTAL General Administration	173,574	4,807	1,709,763	1,888,144	13,152	1,901,296	(657,135)	1,244,161			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,525,530	321,780	2,588,096	5,435,406	(390)	5,435,016	(628,119)	4,806,897			29

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

Facility Name & ID Number Willow Crest Nrsing Pavilion #0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			75,189	75,189		75,189	181,258	256,447			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			34,538	34,538		34,538	205,550	240,088			32
33	Real Estate Taxes			14,333	14,333	390	14,723	28,364	43,087			33
34	Rent-Facility & Grounds			1,054,000	1,054,000		1,054,000	(1,054,000)				34
35	Rent-Equipment & Vehicles			5,926	5,926		5,926	8,410	14,336			35
36	Other (specify):*							73,248	73,248			36
37	TOTAL Ownership			1,183,986	1,183,986	390	1,184,376	(557,170)	627,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	398,379	165,880	1,026	565,285		565,285	(44)	565,241			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			244,463	244,463		244,463		244,463			42
43	Other (specify):*	38,476			38,476		38,476	(38,476)				43
44	TOTAL Special Cost Centers	436,855	165,880	245,489	848,224		848,224	(38,520)	809,704			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,962,385	487,660	4,017,571	7,467,616		7,467,616	(1,223,809)	6,243,807			45

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	125,071	30		9
10	Interest and Other Investment Income	(62,595)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(266)	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	(1,345)	21		18
19	Entertainment				19
20	Contributions	(2,849)	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	(99,000)	21		24
25	Fund Raising, Advertising and Promotional	(44,248)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,745)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(295,794)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (388,772)		$	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)	(835,037)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (835,037)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,223,809)		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

Willow Crest Nrsing Pavilion

ID# 0036533

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (41,814)	21	1
2	Bank Charges	(18,076)	21	2
3	PPA - General Office Expense	(182,855)	21	3
4	PPA - Radiology	(44)	39	4
5	PPA - Interest	(2,348)	32	5
6	Additional R&M	16,807	06	6
7	PAC Dues	(7,011)	20	7
8	Building Company - Franchise Tax	(250)	21	8
9	Building Company - State Replacement Tax	(9,241)	21	9
10	Building Company - Accounting Fees	(7,130)	19	10
11	Building Company - Bank Charges	(89)	21	11
12	Building Company - Office Expense	(27)	21	12
13	Building Company - Amortization	(3,929)	31	13
14	Non-allowable Legal	(1,310)	19	14
15	Marketing Salary	(38,476)	43	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**	(295,794)		49

Willow Crest Nrsing Pavilion

ID# 0036533

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(266)											(266)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			910									910	5
6	Maintenance	16,807		5,413	5,415								27,635	6
7	Other (specify):*			175		562							737	7
8	**TOTAL General Services**	16,541		6,498	5,415	562							29,016	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													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**													16
	C. General Administration													
17	Administrative				105,722								105,722	17
18	Directors Fees													18
19	Professional Services	(8,440)	7,130	(463,035)									(464,345)	19
20	Fees, Subscriptions & Promotions	(54,108)		2,312									(51,796)	20
21	Clerical & General Office Expenses	(360,443)	9,607	57,545	7,569								(285,722)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			831									831	24
25	Other Admin. Staff Transportation			2,986									2,986	25
26	Insurance-Prop.Liab.Malpractice		4,003	(1,032)									2,971	26
27	Other (specify):*			10,225		21,994							32,219	27
28	**TOTAL General Administration**	(422,992)	20,740	(390,168)	113,291	21,994							(657,135)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(406,451)	20,740	(383,670)	118,706	22,556							(628,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nrsing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	125,071	54,375	1,812									181,258	30
31	Amortization of Pre-Op. & Org.	(3,929)	3,929										0	31
32	Interest	(64,943)	268,938	1,555									205,550	32
33	Real Estate Taxes		25,249	3,115									28,364	33
34	Rent-Facility & Grounds		(1,054,000)										(1,054,000)	34
35	Rent-Equipment & Vehicles			8,410									8,410	35
36	Other (specify):*		73,248										73,248	36
37	**TOTAL Ownership**	56,199	(628,261)	14,892									(557,170)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(44)											(44)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(38,476)											(38,476)	43
44	**TOTAL Special Cost Centers**	(38,520)											(38,520)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(388,772)	(607,521)	(368,778)	118,706	22,556							(1,223,809)	45

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	$ 1,054,000	Willow Crest Building Company	100.00%	$	$ (1,054,000)	1
2	V	32	Interest	5,260	Willow Crest Building Company	100.00%	274,198	268,938	2
3	V	21	Franchise Tax		Willow Crest Building Company	100.00%	250	250	3
4	V	21	State Replacement Tax		Willow Crest Building Company	100.00%	9,241	9,241	4
5	V	19	Accounting Fees		Willow Crest Building Company	100.00%	7,130	7,130	5
6	V	21	Bank Charges		Willow Crest Building Company	100.00%	89	89	6
7	V	21	Office Expense		Willow Crest Building Company	100.00%	27	27	7
8	V	33	Real Estate		Willow Crest Building Company	100.00%	25,249	25,249	8
9	V	26	Insurance Expense		Willow Crest Building Company	100.00%	4,003	4,003	9
10	V	36	MIP Expense		Willow Crest Building Company	100.00%	73,248	73,248	10
11	V	30	Depreciation		Willow Crest Building Company	100.00%	54,375	54,375	11
12	V	31	Amortization		Willow Crest Building Company	100.00%	3,929	3,929	12
13	V								13
14	Total			$ 1,059,260			$ 451,739	$ * (607,521)	14

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 910	$ 910	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	5,413	5,413	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	175	175	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	775	775	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	2,312	2,312	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	57,545	57,545	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	831	831	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,986	2,986	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	(1,032)	(1,032)	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	10,225	10,225	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,812	1,812	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,555	1,555	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,115	3,115	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	390	390	28
29	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	8,348	8,348	29
30	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	62	62	30
31	V								31
32	V	19	BOOKKEEPING / HOME OFFICE	464,200	DYNAMIC HEALTH CARE CONS.	100.00%		(464,200)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 464,200			$ 95,422	$ * (368,778)	39

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 5,415	$ 5,415	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	16,248	16,248	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	18,269	18,269	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,200	2,200	18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,805	16,805	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	13,731	13,731	22
23	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	10,368	10,368	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	11,855	11,855	25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	16,246	16,246	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,077	7,077	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	492	492	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 118,706	$ * 118,706	39

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 562	$ 562	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	934	934	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,316	1,316	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,526	7,526	18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,369	1,369	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	983	983	22
23	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,515	2,515	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	3,761	3,761	25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,969	1,969	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,369	1,369	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	252	252	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			$			$ 22,556	$ * 22,556	39

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	FRED L. AARON	13.103448	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	WILLOW CREST BUILDING LLC		BUILDING CO.	1
2	MAURICE I. AARON	23.793104	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULTIN	2
3	SHIMON GOLDSTEIN	21.551724	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MIRIAM LATINIK	4.310345	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	4
5	MARSHALL A. MAUER	10.775862	STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	SHARON S. AARON	.560345	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				6
7	CHANI MAUER	6.051724	WATERFRONT TERRACE, INC.	CHICAGO				7
8	DENNIS NEHMER	.560345	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				8
9	ESTHER MARYLES	6.051724	WOODBRIDGE NURSING PAVILION, LTD.	CHICAGO				9
10	HOWIE & SUSIE ALTER	1.120689	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (	GALESBURG				10
11	SYLVIA AARON	.224138	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				11
12	SUSAN KOPLIN	.560345	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF	PONTIAC				12
13	DIANIA KUFTA	.560345	RIVER NORTH OF BRADLEY HEALTH & REHAB	BRADLEY				13
14	FRANCES MAUER	10.775862						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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	3.25	8.13%	Alloc. Salary	$ 7,077	21-07	1
2	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9	20.00%	Sal/Alloc. Sal	40,700	17-01/17-07	2
3	Maurice Aaron	Shareholder	Administrative	23.79%	See Attached	3.65	7.31%	Alloc. Salary	18,269	17-07	3
4	Marshall Mauer	Shareholder	Administrative	10.78%	See Attached	3.25	6.50%	Alloc. Salary	16,248	17-07	4
5	Diania Kufta	Shareholder	Administrative	0.56%	See Attached	4.57	9.14%	Alloc. Salary	13,731	17-07	5
6	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	3.65	9.13%	Alloc. Salary	5,415	06-07	6
7	Esther Maryles	Shareholder	Clerical	6.05%	See Attached	0.23	0.82%	Alloc. Salary	492	21-07	7
8	Daniel Aaron	Relative	Administrative	0%	See Attached	11.15	27.88%	Alloc. Salary	16,805	17-07	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 118,737		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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	452,396	14	$ 11,795	$	34,911	$ 910	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	452,396	14	70,149	38,885	34,911	5,413	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	452,396	14	2,266		34,911	175	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	14	10,039		34,911	775	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	452,396	14	29,965		34,911	2,312	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	14	745,706	528,878	34,911	57,545	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	14	10,766		34,911	831	7
8	25	AUTO EXP.	PATIENT DAYS	452,396	14	38,698		34,911	2,986	8
9	26	INSURANCE	PATIENT DAYS	452,396	14	(13,379)		34,911	(1,032)	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	452,396	14	132,506		34,911	10,225	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	14	23,478		34,911	1,812	11
12	32	INTEREST	PATIENT DAYS	452,396	14	20,148		34,911	1,555	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	14	40,366		34,911	3,115	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	452,396	14	5,056		34,911	390	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	14	108,178		34,911	8,348	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	14	802		34,911	62	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,236,539	$ 567,763		$ 95,422	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	9	59,284	59,284	3.65	5,415	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.25	16,248	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	3.65	18,269	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	11,000	11,000	9.00	2,200	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	60,271	60,271	11.15	16,805	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	103,196	103,196	-		6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	76,737	76,737	-		7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	9	150,258	150,258	4.57	13,731	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	11	127,632	127,632	3.25	10,368	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	9	129,197	129,197	4.11	11,855	11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.25	16,246	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	87,119	87,119	3.25	7,077	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	60,541	60,541	0.23	492	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,477,235	$ 1,477,235		$ 118,706	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	9	6,150		3.65	562	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,498		3.25	934	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,402		3.65	1,316	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	37,628		9.00	7,526	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,909		11.15	1,369	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,033		-		6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	25,836		-		7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	9	10,754		4.57	983	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,085		-		9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	11	30,956		3.25	2,515	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	40,985		4.11	3,761	11
12	27	EMP. BEN.- CFO (NON-OWNEF	WGHTD. AVG. HOURS	40	11	24,244		3.25	1,969	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	16,859		3.25	1,369	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	30,999		0.23	252	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 293,338	$		$ 22,556	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** 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	HUD		X	Mortgage			$	$ 8,283,755			$ 274,198	1
2	Allocated - Dynamic HC	X									1,555	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				750,000			31,295	6
7												7
8												8
9	TOTAL Facility Related						$	$ 9,033,755			$ 307,048	9
	B. Non-Facility Related*											
10	Other Interest Expense		X								895	10
11	Interest Income		X								(62,595)	11
12	Interest Income - Bldg Co.		X								(5,261)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (66,961)	14
15	TOTALS (line 9+line14)						$	$ 9,033,755			$ 240,086	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 73,248** **Line # 36**

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

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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**		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												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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 43,000	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.)		$ 43,697	2
3. Under or (over) accrual (line 2 minus line 1).		$ 697	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,000	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.)**		$ 390	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 43,087	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	39,059	8
	2010	39,913	9
	2011	40,746	10
	2012	41,732	11
	2013	40,582	12

2014 Accrual = $40,582 x 1.03 = $42,000 (Rounded)

Allocated - Dynamic HC Consultants - $3,115

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nrsing 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Long Term Care Property	$ 40,582.18	$ 40,582.18
2.	10-23-404-059-0000	Long Term Care Property	$ 39,907.32	$ 3,079.61
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 80,489.50	$ 43,661.79

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nrsing 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 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1998	1975	$ 2,544,733	$ 54,375	39	$ 65,250	$ 10,875	$ 1,043,719	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20			21,410	9
10	Various			1991	9,997		20			9,918	10
11	Various			1992	4,279		20			4,275	11
12	Various			1993	26,868		20			26,868	12
13	Various			1994	8,312		20	234	234	8,310	13
14	Various			1995	3,234		20	160	160	3,159	14
15	Various			1996	17,411		20	871	871	15,815	15
16	Various			1997	68,499		20	3,425	3,425	58,339	16
17	Various			1998	31,645		20	1,582	1,582	26,431	17
18	Various			1999	147,088		20	7,297	7,297	112,923	18
19	Various			2000	149,982		20	7,499	7,499	109,116	19
20	Various			2001	139,226		20	6,961	6,961	93,547	20
21	Various			2002	52,106		20	159	159	50,930	21
22	Various			2003	79,602		20			79,602	22
23	Various			2004	54,194		20	1,076	1,076	54,194	23
24	Various			2005	41,185		20	1,590	1,590	39,975	24
25	Various			2006	24,334		20	2,167	2,167	21,435	25
26	Various			2007	36,779		20	3,577	3,577	27,567	26
27	Various			2008	74,672		20	6,925	6,925	59,160	27
28	Various			2009	29,315		20	2,156	2,156	16,163	28
29	Various			2010	48,821		20	2,040	2,040	9,081	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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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
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51									51
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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)								67
68	Related Party Allocations (Pages 12H & 12I)		34,232	878		978	100	20,865	68
69	Financial Statement Depreciation			75,189			(75,189)		69
70	TOTAL (lines 4 thru 69)		$ 3,647,924	$ 130,442		$ 113,946	$ (16,496)	$ 1,912,804	70

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,647,924	$ 130,442		$ 113,946	$ (16,496)	$ 1,912,804	1
2	Rebuilt Water System	2011	3,294		20	84	84	292	2
3	Electrical Wiring And Permanent Kiosks	2011	17,336		20	445	445	1,426	3
4	Bathroom Flooring, Tiling, Grouting	2011	2,818		20	72	72	226	4
5	Bathroom Tiling & Flooring	2011	3,881		20	100	100	303	5
6	Therapy Room- Lighting, Curtains, Flooring, Signage	2011	7,197		20	720	720	2,699	6
7	Fire Alarm System Repair	2011	3,173		20	317	317	1,269	7
8	Driveway Resurfacing	2011	9,398		20	940	940	3,524	8
9	Electrical Wiring And Permanent Kiosks	2011	6,879		20	688	688	2,178	9
10	Kitchen And Showers-2Nd Fl-Wall/Support Brace/Locks/Painting	2012	2,569		20	514	514	1,370	10
11	2Nd Fl Nurse Stat./Bathrooms-Sinks/Shelving/Support/Counter2N	2012	7,329		20	1,466	1,466	3,786	11
12	Dining Room/Lobby/Computer Room-WallcoveringsDining Room/	2012	3,526		20	705	705	1,822	12
13	2Nd Floor Bathroom Vanity, Sinks, Window, Faucet	2012	9,073		20	233	233	553	13
14	2Nd Floor- Walllcovering, Painting, Supports	2012	2,775		20	555	555	1,388	14
15	Handrail And Crash Rail- 2Nd Floor Hallway	2012	16,806		20	3,361	3,361	8,403	15
16	Floors/Wallcovering-2Nd Fl Nurse St/Dining/Lobby/Corridors	2012	31,447		20	6,289	6,289	15,724	16
17	2Nd Floor Res Rooms/Corridors- Ceiling Tiles/Wallcoverings/Floo	2012	6,002		20	1,200	1,200	2,901	17
18	2Nd Floor Res Rooms/Corridors- Window Treatments	2012	4,178		20	836	836	2,019	18
19	Signage - In Front Of Doors	2012	3,029		20	606	606	1,464	19
20	Lighting In Dining Room/Library/Nurses Station/Corridor	2012	10,222		20	2,044	2,044	4,941	20
21	Cabinetry For 2Nd Floor Nurses Station	2012	12,664		20	2,533	2,533	6,121	21
22	Carpeting/Floor Coverings:2Nd Fl. Rooms/Corridors/Stations	2012	20,150		20	4,030	4,030	9,403	22
23	New Vanity/Countertops/Sinks In Kitchen And Bathroom	2012	4,946		20	127	127	291	23
24	Security Equipment	2012	3,185		20	637	637	1,486	24
25	2Nd Fl.Bathrms/Boiler-Laundry Rm- Plumbing/Vanity/Flooring	2012	4,982		20	996	996	2,242	25
26	2Nd Floor Bathroom/Kitchen- Cabinets/Walls/Flooring	2012	10,383		20	2,077	2,077	4,672	26
27	Elevator Work	2013	2,560		20	128	128	245	27
28	Installed New Hydraulic Oil In Elevators	2013	8,155		20	408	408	782	28
29	Resident Bathroom Countertops - 2Nd Floor	2013	4,596		20	118	118	211	29
30	Bthrm Trim Molding, Mirror, Grout, Light Fixtures - 2Nd Floor	2013	4,473		20	895	895	1,640	30
31	Installed Upper And Lower Cabinetry - 2Nd Floor	2013	3,850		20	770	770	1,348	31
32	Smoke Alarm, Safety Guard, Bathroom Lock, Plumbing - 2Nd Floo	2013	3,324		20	665	665	1,164	32
33	Light Fixtures In Resident Rooms - 2Nd Floor	2013	7,699		20	1,540	1,540	2,695	33
34	TOTAL (lines 1 thru 33)		$ 3,889,823	$ 130,442		$ 150,043	$ 19,601	$ 2,001,390	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,889,823	$ 130,442		$ 150,043	$ 19,601	$ 2,001,390	1
2	New Grease Trap In Kitchen	2013	6,073		20	156	156	253	2
3	Build Out Kitchen And Install Grease Traps	2013	11,804		20	303	303	441	3
4	Woodframes And Boards - 2Nd Floor	2013	7,746		20	199	199	290	4
5	Light Fixtures , Curtains, Window Treatments, Floor - 2Nd Floor	2013	67,805		20	13,561	13,561	20,341	5
6	Install Carpet Covering - 2Nd Floor	2013	8,208		20	1,642	1,642	2,325	6
7	Fixtures And Lighting - 2Nd Floor	2013	4,972		20	994	994	1,409	7
8	Outlets For 1St Floor	2013	4,072		20	814	814	1,018	8
9	Security Equip	2013	2,895		20	579	579	724	9
10	Security Equip	2013	3,395		20	679	679	792	10
11	Molding, Towel Bar For First Floor Bathrooms	2013	10,408		20	2,082	2,082	2,255	11
12	Rewired Indicating Circuits And Installed New Fire Alarm System	2014	4,950		20	248	248	248	12
13	1St Floor, Bathroom-Piping,Tile,Drywall,Outlets,Painting,Lighting	2014	6,997		20	350	350	350	13
14	1St Floor Ceiling-Tile	2014	2,621		20	131	131	131	14
15	1St Floor - Countertops And Shelving	2014	19,084		20	954	954	954	15
16	1St Floor - Flooring	2014	11,689		20	584	584	584	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)		$ 4,062,541	$ 130,442		$ 173,318	$ 42,876	$ 2,033,506	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,062,541	$ 130,442		$ 173,318	$ 42,876	$ 2,033,506	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)		$ 4,062,541	$ 130,442		$ 173,318	$ 42,876	$ 2,033,506	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,062,541	$ 130,442		$ 173,318	$ 42,876	$ 2,033,506	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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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)		$ 4,062,541	$ 130,442		$ 173,318	$ 42,876	$ 2,033,506	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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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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)		$	$		$	$	$	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - Dynamic HC Consultants	1993	34,232	878	35	978	100	20,865	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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)		$ 34,232	$ 878		$ 978	$ 100	$ 20,865	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 34,232	$ 878		$ 978	$ 100	$ 20,865	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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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)		$ 34,232	$ 878		$ 978	$ 100	$ 20,865	34

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 600,976	$ 48	$ 78,025	$ 77,977	10	$ 389,776	71
72	Current Year Purchases	26,487	498	2,059	1,561	10	2,059	72
73	Fully Depreciated Assets	936,450		36	36	10	936,374	73
74								74
75	TOTALS	$ 1,563,912	$ 546	$ 80,120	$ 79,574		$ 1,328,209	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2004	$ 44,500	$	$	$	5	$ 44,500	76
77		Used Van	2005	16,080				5	16,080	77
78		Allocated - Dynamic HC Consult	1905	18,188	388	3,009	2,621	5	11,483	78
79										79
80	TOTALS			$ 78,768	$ 388	$ 3,009	$ 2,621		$ 72,063	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)	$ 6,033,080	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,376	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 256,447	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 125,071	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,433,778	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	Various Improvements	$ 169,105	92
93	Abt Deposit	500	93
94			94
95		$ 169,605	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 Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 2,520 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	Facility	2014 Dodge	$ 578.00	$ 3,468	17
18	Allocated - Dynamic HC Consultants			8,348	18
19					19
20					20
21	TOTAL		$ 578.00	$ 11,816	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 202,425		$	$		$ 202,425	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	21,588					21,588	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	174,366					174,366	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				146,625		146,625	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					1,026	19,255		20,281	13
14	TOTAL			$ 398,379		$ 1,026	$ 165,880		$ 565,285	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 150,254	$ 402,069	1
2	Cash-Patient Deposits	35,860	35,860	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,170,952	1,170,952	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,611	109,577	6
7	Other Prepaid Expenses	3,374	3,374	7
8	Accounts Receivable (owners or related parties)		19,001	8
9	Other(specify):	9,583	920,447	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,455,634	$ 2,661,280	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	1,502,292	1,502,292	15
16	Equipment, at Historical Cost	1,307,654	1,713,654	16
17	Accumulated Depreciation (book methods)	(2,089,793)	(3,542,506)	17
18	Deferred Charges		157,151	18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(9,929)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,425,288	1,425,288	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,145,441	$ 4,124,542	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,601,075	$ 6,785,822	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 292,015	$ 294,845	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,860	35,860	28
29	Short-Term Notes Payable	750,000	901,583	29
30	Accrued Salaries Payable	260,673	260,673	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,547	4,547	31
32	Accrued Real Estate Taxes(Sch.IX-B)		42,000	32
33	Accrued Interest Payable	9,920	37,533	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,199	11,199	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	157,309	157,309	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,521,523	$ 1,745,549	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,132,172	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,132,172	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,521,523	$ 9,877,721	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,079,552	$ (3,091,899)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,601,075	$ 6,785,822	48

*(See instructions.)

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,852,715	1	
2	Restatements (describe):		2	
3	**Rounding**	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,852,716	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	366,036	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	(139,200)	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)**	$ 226,836	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)**	$ 2,079,552	24	*

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,337,255	1
2	Discounts and Allowances for all Levels	(1,509,072)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,828,183	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,615,270	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,615,270	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	214,943	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,543	19
20	Radiology and X-Ray	9,927	20
21	Other Medical Services	13,191	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 273,604	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,595	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,595	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	54,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,833,652	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,084,756	31
32	Health Care	2,462,506	32
33	General Administration	1,888,144	33
	B. Capital Expense		
34	Ownership	1,183,986	34
	C. Ancillary Expense		
35	Special Cost Centers	603,761	35
36	Provider Participation Fee	244,463	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,467,616	40
41	**Income before Income Taxes (line 30 minus line 40)****	366,036	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 366,036	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,477,379	44
45	Private Pay - Net Inpatient Revenue	1,303,812	45
46	Medicare - Net Inpatient Revenue	1,011,523	46
47	Other-(specify) Hospice - Net Inpatient Revenue	35,469	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,828,183	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2,244	2,524	$ 114,885	$ 45.52	1
2	Assistant Director of Nursing	2,475	2,715	113,224	41.70	2
3	Registered Nurses	18,591	19,920	563,295	28.28	3
4	Licensed Practical Nurses	10,944	11,996	312,683	26.07	4
5	CNAs & Orderlies	72,027	76,803	899,692	11.71	5
6	CNA Trainees					6
7	Licensed Therapist	8,819	9,331	398,379	42.69	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,841	2,097	52,429	25.00	9
10	Activity Assistants	9,367	10,118	92,544	9.15	10
11	Social Service Workers	4,895	5,221	88,820	17.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,035	2,203	55,892	25.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,332	2,548	138,402	54.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,717	1,900	35,172	18.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,329	1,441	27,575	19.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,905	4,018	69,393	17.27	33
34	TOTAL (lines 1 - 33)	142,521	152,835	$ 2,962,385 *	$ 19.38	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	240	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	204	7,187	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	33	1,677	11-03	44
45	Social Service Consultant	70	4,448	12-03	45
46	Other(specify)				46
47	Outside Dietary Services		394,317	01-03	47
48					48
49	TOTAL (lines 35 - 48)	547	$ 419,629		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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Ingold	Administrator	0	$ 99,902
Fred Aaron	Administrative	13.10	38,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,402

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
eHealth Data Solutions	Risk Management Software	$ 4,431
Dynamic HC Consultants	Data Processing	10,359
Casamba	EMR for Therapy	3,600
Health Data Systems	Clinical / E.H.R.	4,510
National Data Corporation	Data Processing	2,067
Dynamic HC Consultants	Bookkeeping/Home Office	464,200
Frost, Ruttenberg & Rothblatt	Accounting	19,513
Personnel Planners	Unemployment Consulting	1,975
Dynamic HC Consultants	Professional Fees	119
Joint Commission	Environment of Care Consult	1,200
Robert L. Varnes & Associates	Architectural Consulting	650
See Supplemental Schedule		28,246
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 540,869

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,418
Unemployment Compensation Insurance	37,719
FICA Taxes	221,153
Employee Health Insurance	172,729
Employee Meals	13,542
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	19,108
TOTAL (agree to Schedule V, line 22, col.8)	$ 534,669

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,798
Health Care Worker Background Check	
(Indicate # of checks performed 333)	3,335
Patient Background Checks	
Dues and Subcriptions	6,264
Licenses and Permits	16,030
Allocated - Dynamic HC Consultants	2,312
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,739

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,875
Allocated - Dynamic HC Consultants	831
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,706

**See instructions.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Willow Crest Nrsing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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. **ICLTC $11,971**

(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. $ **2,335** Line **10-02**

(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. $ **244,463**
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. $ **13,542** 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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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