

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0020792</u></p> <p>Facility Name: <u>WILLOWS HEALTH CENTER</u></p> <p>Address: <u>4054 ALBRIGHT LANE</u> <u>ROCKFORD</u> <u>61103</u> Number City Zip Code</p> <p>County: <u>WINNEBAGO</u></p> <p>Telephone Number: <u>(815)-654-2530</u> Fax # <u>(815)-654-2545</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/01/1972</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>MARK TICKNOR</u> Telephone Number: <u>(815)-316-1518</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p style="text-align: center;">I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2013</u> to <u>06/30/2014</u> 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.</p> <p style="text-align: center;">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>MARK TICKNOR</u> (Title) <u>TREASURER</u></td> </tr> <tr> <td style="width: 20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p style="text-align: center; margin-top: 10px;"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MARK TICKNOR</u> (Title) <u>TREASURER</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
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	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MARK TICKNOR</u> (Title) <u>TREASURER</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																												

Facility Name & ID Number WILLOWS HEALTH CENTER

0020792 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	36	Sheltered Care (SC)	36	13,140	5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,650	23,555	4,071	30,276	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		12,864		12,864	12
13	DD 16 OR LESS					13
14	TOTALS	2,650	36,419	4,071	43,140	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.06%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Outpatient therapy

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/01/1972

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 20 and days of care provided 3,332

Medicare Intermediary NHIC

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2014 Fiscal Year: 06/30/2014

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	799,152	94,152		893,304		893,304	893,304			1
2	Food Purchase		436,752		436,752		436,752	436,752			2
3	Housekeeping	181,092	27,696	746	209,534		209,534	209,534			3
4	Laundry	32,112	152,278		184,390		184,390	184,390			4
5	Heat and Other Utilities			182,753	182,753		182,753	182,753			5
6	Maintenance	113,316	83,950	132,706	329,972		329,972	329,972			6
7	Other (specify):* HR/Marketing	128,945	2,435	56,798	188,178		188,178	(48)	188,130		7
8	TOTAL General Services	1,254,617	797,263	373,003	2,424,883		2,424,883	(48)	2,424,835		8
	B. Health Care and Programs										
9	Medical Director	34,703			34,703		34,703	34,703			9
10	Nursing and Medical Records	3,702,133	365,420	818,023	4,885,576		4,885,576	4,885,576			10
10a	Therapy										10a
11	Activities										11
12	Social Services	222,297	2,447	15,479	240,223		240,223	240,223			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,959,133	367,867	833,502	5,160,502		5,160,502	5,160,502			16
	C. General Administration										
17	Administrative	271,058			271,058		271,058	271,058			17
18	Directors Fees										18
19	Professional Services			49,751	49,751		49,751	49,751			19
20	Dues, Fees, Subscriptions & Promotions			163,866	163,866		163,866	163,866			20
21	Clerical & General Office Expenses	177,184	23,522	12,084	212,790		212,790	212,790			21
22	Employee Benefits & Payroll Taxes			1,185,509	1,185,509		1,185,509	1,185,509			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,135	1,135		1,135	1,135			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			131,611	131,611		131,611	131,611			26
27	Other (specify):* MISCELLANEOUS			21,461	21,461		21,461	(25,881)	(4,420)		27
28	TOTAL General Administration	448,242	23,522	1,565,417	2,037,181		2,037,181	(25,881)	2,011,300		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,661,992	1,188,652	2,771,922	9,622,566		9,622,566	(25,929)	9,596,637		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

WILLOWS HEALTH CENTER

#0020792

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			464,972	464,972	464,972		464,972				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			464,972	464,972	464,972		464,972				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823	49,823		49,823				42
43	Other (specify):* DEVELOPMENT			75,546	75,546	75,546		(75,546)				43
44	TOTAL Special Cost Centers			125,369	125,369	125,369		(75,546)	49,823			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,661,992	1,188,652	3,362,263	10,212,907	10,212,907		(101,475)	10,111,432			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 **WILLOWS HEALTH CENTER**

0020792

Report Period Beginning: **07/01/2013**

Ending: **06/30/2014**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	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	25,881			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	75,546			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	48			28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 101,475		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 101,475		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

WILLOWS HEALTH CENTERID# 0020792Report Period Beginning: 07/01/2013Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Telephone, TV & Radio in Resident Rooms	\$ (25,881)	27	1
2	Fund Raising, Advertising and Promotional	(75,546)	43	2
3	Yellow Page Advertising	(48)	7	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(101,475)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOWS HEALTH CENTER# 0020792

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(48)	0	0	0	0	0	0	0	0	0	0	(48)	7
8	TOTAL General Services	(48)	0	0	0	0	0	0	0	0	0	0	(48)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(25,881)	0	0	0	0	0	0	0	0	0	0	(25,881)	27
28	TOTAL General Administration	(25,881)	0	0	0	0	0	0	0	0	0	0	(25,881)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,929)	0	0	0	0	0	0	0	0	0	0	(25,929)	29

STATE OF ILLINOIS

Facility Name & ID Number WILLOWS HEALTH CENTER# 0020792

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(75,546)	0	0	0	0	0	0	0	0	0	0	(75,546)	43
44	TOTAL Special Cost Centers	(75,546)	0	0	0	0	0	0	0	0	0	0	(75,546)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(101,475)	0	0	0	0	0	0	0	0	0	0	(101,475)	45

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
Willows Health Center	100			Wesley Willows	Rockford	CCRC

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Management Fee	\$ 4,200	Wesley Willows	0.00%	\$ 4,200	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 4,200			\$ 4,200	\$ *	14

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

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	Erin Calkins	BOD						1
2	Linda Chang	BOD						2
3	Joe Clinton	BOD						3
4	Mike Davis	BOD						4
5	Lori Diaz	BOD						5
6	Michael Gann	BOD						6
7	Monica Glenny	BOD						7
8	Anne Hammes	BOD						8
9	Mark McClenathan	BOD						9
10	David Schmitt	BOD						10
11	John Shockey	BOD						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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Erin Calkins	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	\$ 0	1
2	Linda Chang	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	2
3	Joe Clinton	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	3
4	Mike Davis	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	4
5	Lori Diaz	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	5
6	Michael Gann	BOD PRESIDENT	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	6
7	Monica Glenny	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	7
8	Anne Hammes	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	8
9	Mark McClenathan	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	9
10	David Schmitt	BOD VICE-PRES	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	10
11	John Shockey	BOD MEMBER	VOLUNTEER	0.00	0	N/A	N/A	N/A	0	11
12										12
13								TOTAL	\$	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 WILLOWS HEALTH CENTER

0020792 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$			1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2														
3. Under or (over) accrual (line 2 minus line 1).		\$			3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			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
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																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

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 WILLOWS HEALTH CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0020792

CONTACT PERSON REGARDING THIS REPORT MARK TICKNOR

TELEPHONE (815)-316-1518 FAX #: (815)-316-1490

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		TOTALS	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

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

C. **Tax Bills**

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER

0020792 Report Period Beginning:

07/01/2013 Ending:

06/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,025 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>100,000</u>	<u>1974</u>	<u>\$ 14,007</u>	1
2	<u>Nursing Home</u>	<u>30,680</u>	<u>1994</u>	<u>7,729</u>	2
3	TOTALS	130,680		\$ 21,736	3

Facility Name & ID Number **WILLOWS HEALTH CENTER**# **0020792**

Report Period Beginning:

07/01/2013

Ending:

06/30/2014**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	127		1974	1974	\$ 1,138,143	\$ 22,763	50	\$ 22,763	\$	\$ 910,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1996		1,027,018	25,675	40	25,675		462,150	9
10	VARIOUS		1999		276,540	13,974	5-20	13,974		222,039	10
11	VARIOUS		2000		25,023	1,266	20	1,266		17,829	11
12	VARIOUS		2001		124,603	6,111	7-20	6,111		124,603	12
13	VARIOUS		2002		108,978	6,920	7-20	6,920		83,018	13
14	VARIOUS		2003		275,984	20,217	10-20	20,217		217,744	14
15	VARIOUS		2004		47,559	3,499	10-20	3,499		34,906	15
16	VARIOUS		2005		38,401	2,470	10-20	2,470		22,897	16
17	VARIOUS		2006		352,273	23,485	15	23,485		193,396	17
18	VARIOUS		2007		17,691	1,180	15	1,180		8,159	18
19	FLOORING		2008		15,514	1,034	15	1,034		6,327	19
20	DOOR CLOSERS		2008		46,479	3,099	15	3,099		19,148	20
21	MIXING VALVE		2008		4,700	313	15	313		1,951	21
22	LOCKER ROOM RENOVATIONS		2008		9,432	629	15	629		3,564	22
23	AIR DRYER		2008		3,780	252	15	252		1,442	23
24	ALARMING		2008		1,176	78	15	78		443	24
25	FLOORING		2009		24,320	1,621	15	1,621		8,265	25
26	ROOFING		2009		5,888	393	15	393		2,030	26
27	ALARMING		2009		3,024	202	15	202		1,031	27
28	ELEVATOR REBUILD		2009		12,689	846	15	846		4,371	28
29	GENERATOR UPGRADE		2009		13,139	876	15	876		4,185	29
30	CALL SYSTEM UPGRADE		2009		5,378	359	15	359		1,765	30
31	CHILLERS		2009		3,136	209	15	209		1,010	31
32	KITCHEN HOOD		2009		4,553	304	15	304		1,494	32
33	ENTRYWAY COLUMNS		2010		4,800	320	15	320		1,280	33
34	RADIO SYSTEM UPGRADE		2010		3,622	419	15	419		1,562	34
35	INTAKE AIR FAN		2010		2,267	151	15	151		642	35
36	FLOORING ROOM F15		2010		2,204	147	15	147		636	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOORING AND CEILING PANELS D109&F102	2010	\$ 2,741	\$ 183	15	\$ 183	\$	\$ 671	37
38	UNDERCOUNTER FREEZER UNIT	2010	2,353	157	15	157		574	38
39	FLOORING F5&6, D114,118,120,123,126&127	2011	9,530	635	15	635		2,068	39
40	CHILLED WATER SYSTEM BOILER UPDATE	2011	5,369	358	15	358		1,164	40
41	FLOORING F3,106,108&120, D115&122	2011	6,190	413	15	413		1,127	41
42	CHILLER LANDSCAPING	2011	5,925	395	15	395		987	42
43	DOOR REPLACEMENTS, BREEZEWAY, PC ENTR, MAIN	2012	31,246	2,083	15	2,083		4,601	43
44	KEYS AND LOCK RESET	2012	582	39	15	39		91	44
45	FLOORING F1,15&101, D110	2012	5,345	356	15	356		750	45
46	WINDOW REPLACEMENT COMPLETE BUILDING	2012	207,920	13,861	15	13,861		28,940	46
47	YORK CONDENSING UNIT	2012	5,986	399	15	399		865	47
48	GAS FIRED BOILER AND HOT WATER PUMPS	2013	411,152	16,608	15-40	16,608		24,915	48
49	KITCHEN MAKEUP UNIT	2013	54,703	3,647	15	3,647		5,395	49
50	MEDICARE RM COMPLETE RENOVATION 15 RMS 20 BEDS	2013	346,397	30,021	10	30,021		30,021	50
51	D1-1&2,D2,D3-1&2,D4,D5-1&2,D6,D7-1&2,D8,D9-1&2,D10								51
52	D11,D12,D13,D14,D15 INCLUDING FLOORING, ELECTRICAL								52
53	LIGHTING, PLUMBING, DOORS FIXTURES AND PAINTING								53
54									54
55	HOT WATER SYSTEM UPGRADE	2013	40,314	3,024	10	3,024		3,024	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,734,067	\$ 210,991		\$ 210,991	\$	\$ 2,463,600	70

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

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	\$ 3,997,754	\$ 246,391	\$ 246,391	\$		\$ 2,388,039	71
72	Current Year Purchases	116,218	7,590	7,590			7,590	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,113,972	\$ 253,981	\$ 253,981	\$		\$ 2,395,629	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,869,775	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 464,972	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 464,972	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,859,229	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

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

Facility Name & ID Number **WILLOWS HEALTH CENTER**# **0020792**Report Period Beginning: **07/01/2013**Ending: **06/30/2014****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2014**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,089,154	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 1,175,000)	451,380		3
4	Supply Inventory (priced at Cost)	12,490		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,553,024	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,736		13
14	Buildings, at Historical Cost	4,734,067		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,073,658		16
17	Accumulated Depreciation (book methods)	(4,859,229)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,615		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,974,847	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,527,871	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 457,315	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,651		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 673,966	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 673,966	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,853,905	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,527,871	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,223,269	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,223,269	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(369,096)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(268)	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (369,364)	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)	\$ 4,853,905	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,750,821	1
2	Discounts and Allowances for all Levels	(1,489,184)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,261,637	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,548,799	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,548,799	23
D. Non-Operating Revenue			
24	Contributions	33,375	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,375	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,843,811	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,424,883	31
32	Health Care	5,160,502	32
33	General Administration	2,037,181	33
B. Capital Expense			
34	Ownership	464,972	34
C. Ancillary Expense			
35	Special Cost Centers	75,546	35
36	Provider Participation Fee	49,823	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,212,907	40
41	Income before Income Taxes (line 30 minus line 40)**	(369,096)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (369,096)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **WILLOWS HEALTH CENTER**

0020792

Report Period Beginning: **07/01/2013**

Ending:

06/30/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 87,116	\$ 41.88	1
2	Assistant Director of Nursing	4,277	4,448	118,989	26.75	2
3	Registered Nurses	19,099	19,864	531,350	26.75	3
4	Licensed Practical Nurses	31,619	32,885	746,490	22.70	4
5	CNAs & Orderlies	148,110	154,041	2,218,188	14.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	13,632	14,178	222,297	15.68	11
12	Dietician	2,000	2,080	38,563	18.54	12
13	Food Service Supervisor	6,600	6,864	88,374	12.88	13
14	Head Cook	4,000	4,160	72,842	17.51	14
15	Cook Helpers/Assistants	43,656	45,404	455,966	10.04	15
16	Dishwashers	14,874	15,470	143,407	9.27	16
17	Maintenance Workers	7,163	7,450	113,316	15.21	17
18	Housekeepers	18,523	19,265	181,092	9.40	18
19	Laundry	3,423	3,560	32,112	9.02	19
20	Administrator	1,000	1,040	66,062	63.52	20
21	Assistant Administrator					21
22	Other Administrative	3,000	3,120	204,996	65.70	22
23	Office Manager					23
24	Clerical	10,187	10,595	177,184	16.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	500	500	34,703	69.41	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>HR/Marketing</u>	5,774	6,005	128,945	21.47	33
34	TOTAL (lines 1 - 33)	339,437	353,009	\$ 5,661,992 *	\$ 16.04	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	500	34,703	9-1	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	500	\$ 34,703		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,112	\$ 84,472	10-1	50
51	Licensed Practical Nurses	1,207	42,236	10-1	51
52	Certified Nurse Assistants/Aides	14,783	295,651	10-1	52
53	TOTAL (lines 50 - 52)	18,101	\$ 422,359		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Debra Adkins	Administrator	0	\$ 66,062	Workers' Compensation Insurance	\$ 161,328	IDPH License Fee	\$		
Melissa Laffey	Asst to CEO	0	16,287	Unemployment Compensation Insurance	16,828	Advertising: Employee Recruitment			
Bill Pratt	CEO	0	124,495	FICA Taxes	363,038	Health Care Worker Background Check			
Mark Ticknor	CFO	0	64,214	Employee Health Insurance	524,468	(Indicate # of checks performed <u>54</u>)			
				Employee Meals		Patient Background Checks	189		
				Illinois Municipal Retirement Fund (IMRF)*		Dues	16,546		
				403b Retirement Plan	119,847	LTC Provider Assessment	147,320		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 271,058						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel	1,135	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,185,509	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								\$ 163,866	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Wesley Willows	Mgmt Fee	\$ 4,200				\$			
Nexus	Copier / Office Equip	2,418							
McGladrey/FRR	Audit & Consulting	10,975							
AOD/Entre	Computer services	32,158							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Seminar Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 49,751					(agree to Sch. V, line 24, col. 8)	
								Entertainment Expense ()	
								TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 1,135	

* Attach copy of IMRF notifications

**See instructions.

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

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. LSN, UMA, Leading Age
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,987 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,823
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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? 0
 - 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? Yes
Firm Name: McGladrey
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V LINE 7 EQUALS COST OF HR AND MARKETING DEPTS

SCHEDULE V LINE 24 (TRAVEL AND SEMINAR) DETAILS ATTACHED

TRAVEL	\$ 1,135
MILEAGE REIMBURSEMENT	-
TOTAL	<u>\$ 1,135</u>

SCHEDULE V LINE 27 (MISCELLANEOUS) DETAILS ATTACHED

PAYROLL PROCESSING	\$ 16,169
BACKGROUND CHECKS	2,864
BEAUTY SHOP COSTS	54,525
REVERSAL OF DINING SERVICES ACCRUAL	(82,200)
MISCELLANEOUS	4,222
TOTAL	<u>\$ (4,420)</u>

WILLOWS HEALTH CENTER 0020792

7/01/2013 TO 6/30/2014

SCHEDULE V LINE 43

DEVELOPMENT COSTS INCLUDE COST TO RAISE CONTRIBUTIONS

PAGE 21 , SECTION C LEGAL FEES

NO LEGAL FEES IN 2014

PAGE 25

SCHEDULE XIII, SECTION A1

NO TRAINING COSTS

AIDES ARE TRAINED AT THE LOCAL COMMUNITY COLLEGE,

ROCK VALLEY COMMUNITY COLLEGE

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