FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/16 Ending: 12/31/16

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	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	8	Intermediate (ICF)	8	2,928	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,236	499	6,816	9,551	8
9	SNF/PED					9
10	ICF	20,790	6,810	895	28,495	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,026	7,309	7,711	38,046	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.61%

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 6,350

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		1,888	403,467	405,355		405,355		405,355			1
2	Food Purchase		129,601		129,601	(12,938)	116,663	(247)	116,416			2
3	Housekeeping		1,154	165,768	166,922		166,922		166,922			3
4	Laundry		7,277	102,536	109,813		109,813		109,813			4
5	Heat and Other Utilities			114,733	114,733		114,733	972	115,705			5
6	Maintenance	63,515	68,697	89,746	221,958		221,958	63,445	285,403			6
7	Other (specify):*							864	864			7
8	TOTAL General Services	63,515	208,617	876,250	1,148,382	(12,938)	1,135,444	65,034	1,200,478			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,221,326	142,095	8,127	2,371,548		2,371,548		2,371,548			10
10a	Therapy		6,656		6,656		6,656		6,656			10a
11	Activities	208,190	12,691	2,035	222,916		222,916		222,916			11
12	Social Services	75,247		5,247	80,494		80,494		80,494			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,504,763	161,442	27,409	2,693,614		2,693,614		2,693,614			16
	C. General Administration											
17	Administrative	154,624			154,624		154,624	137,252	291,876			17
18	Directors Fees											18
19	Professional Services			708,655	708,655		708,655	(587,070)	121,585			19
20	Dues, Fees, Subscriptions & Promotions			116,305	116,305		116,305	(40,358)	75,947			20
21	Clerical & General Office Expenses	135,812	5,256	264,725	405,793		405,793	(169,611)	236,182			21
22	Employee Benefits & Payroll Taxes			567,768	567,768	12,938	580,706	(1,896)	578,810			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,630	11,630		11,630	1,813	13,443			24
25	Other Admin. Staff Transportation			14,789	14,789		14,789	1,515	16,304			25
26	Insurance-Prop.Liab.Malpractice			143,561	143,561		143,561	8,386	151,947			26
27	Other (specify):*							49,098	49,098			27
28	TOTAL General Administration	290,436	5,256	1,827,433	2,123,125	12,938	2,136,063	(600,872)	1,535,191			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,858,714	375,315	2,731,092	5,965,121		5,965,121	(535,838)	5,429,283			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: 01/01/16 Ending: 12/31/16

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			170,157	170,157		170,157	103,841	273,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,276	31,276		31,276	279,493	310,769			32
33	Real Estate Taxes							46,881	46,881			33
34	Rent-Facility & Grounds			1,066,599	1,066,599		1,066,599	(1,066,599)				34
35	Rent-Equipment & Vehicles			31,190	31,190		31,190	(1,178)	30,013			35
36	Other (specify):*							52,303	52,303			36
37	**TOTAL Ownership**			1,299,222	1,299,222		1,299,222	(585,259)	713,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	460,925	235,089		696,014		696,014		696,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,305	256,305		256,305		256,305			42
43	Other (specify):*	69,047		1,900	70,947		70,947	(70,947)	0			43
44	**TOTAL Special Cost Centers**	529,972	235,089	258,205	1,023,266		1,023,266	(70,947)	952,319			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,388,686	610,404	4,288,519	8,287,609		8,287,609	(1,192,044)	7,095,566			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: 01/01/16 Ending: 12/31/16

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	(44,360)	30		9
10	Interest and Other Investment Income	(44,369)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(247)	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	(22,640)	21		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	(189,173)	21		24
25	Fund Raising, Advertising and Promotional	(36,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,026)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(199,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (541,617)		$	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)	(650,427)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (650,427)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,192,044)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Travel - Marketing	$ (1,900)	43	1
2	Equipment Rental - P.P.	(6,018)	35	2
3	Employee Benefits - P.P.	(1,896)	22	3
4	Sequestration Expense	(47,015)	21	4
5	Bank Charges	(17,743)	21	5
6	Building Company - Accounting Fees	(15,680)	19	6
7	Building Company - Bookkeeping Fees	(650)	19	7
8	Building Company - Amortization Expense	(5,238)	36	8
9	Non-allowable Auto Lease	(6,936)	35	9
10	Additional R&M	35,423	06	10
11	Marketing Salaries	(69,047)	43	11
12	PAC Dues	(5,623)	20	12
13	Non-allowable Legal	(3,633)	19	13
14	Capitalized R&M - Building Company	(53,537)	06	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(199,494)		49

Willow Crest Nrsing Pavilion

ID# 0036533

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nrsing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(247)											(247)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			972									972	5
6	Maintenance	(18,114)	68,937	6,220	6,402								63,445	6
7	Other (specify):*			200		664							864	7
8	**TOTAL General Services**	(18,361)	68,937	7,392	6,402	664							65,034	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				137,252								137,252	17
18	Directors Fees													18
19	Professional Services	(19,963)	16,330	(583,437)									(587,070)	19
20	Fees, Subscriptions & Promotions	(41,931)		1,573									(40,358)	20
21	Clerical & General Office Expenses	(281,597)	5,026	97,790	9,170								(169,611)	21
22	Employee Benefits & Payroll Taxes	(1,896)											(1,896)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,813									1,813	24
25	Other Admin. Staff Transportation			1,515									1,515	25
26	Insurance-Prop.Liab.Malpractice		5,489	2,897									8,386	26
27	Other (specify):*			16,372		32,726							49,098	27
28	**TOTAL General Administration**	(345,388)	26,845	(461,477)	146,422	32,726							(600,872)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(363,749)	95,782	(454,085)	152,824	33,390							(535,838)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(44,360)	145,578	2,623									103,841	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(44,369)	321,579	2,283									279,493	32
33	Real Estate Taxes		43,049	3,832									46,881	33
34	Rent-Facility & Grounds		(1,066,599)										(1,066,599)	34
35	Rent-Equipment & Vehicles	(12,954)		11,776									(1,178)	35
36	Other (specify):*	(5,238)	57,541										52,303	36
37	TOTAL Ownership	(106,921)	(498,852)	20,514									(585,259)	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													42
43	Other (specify):*	(70,947)											(70,947)	43
44	TOTAL Special Cost Centers	(70,947)											(70,947)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(541,617)	(403,070)	(433,571)	152,824	33,390							(1,192,044)	45

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,066,599	Willow Crest Building LLC	100.00%	$	$ (1,066,599)	1
2	V	32	Interest	337	Willow Crest Building LLC	100.00%	321,916	321,579	2
3	V	21	State Replacement Tax		Willow Crest Building LLC	100.00%	5,026	5,026	3
4	V	19	Accounting Fees		Willow Crest Building LLC	100.00%	15,680	15,680	4
5	V	19	Bookkeeping Fees		Willow Crest Building LLC	100.00%	650	650	5
6	V	06	Repairs & Maintenance		Willow Crest Building LLC	100.00%	68,937	68,937	6
7	V	33	Real Estate Taxes		Willow Crest Building LLC	100.00%	43,049	43,049	7
8	V	26	Insurance Expense		Willow Crest Building LLC	100.00%	5,489	5,489	8
9	V	36	MIP Expense		Willow Crest Building LLC	100.00%	52,303	52,303	9
10	V	30	Depreciation Expense		Willow Crest Building LLC	100.00%	145,578	145,578	10
11	V	36	Amortization Expense		Willow Crest Building LLC	100.00%	5,238	5,238	11
12	V								12
13	V								13
14	Total			$ 1,066,936			$ 663,866	$ * (403,070)	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: 01/01/16 Ending: 12/31/16

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%	$ 972	$ 972	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	6,220	6,220	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	200	200	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	5,463	5,463	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,573	1,573	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	97,790	97,790	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,813	1,813	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,515	1,515	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	2,897	2,897	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	16,372	16,372	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	2,623	2,623	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	2,283	2,283	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,832	3,832	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%			28
29	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	11,021	11,021	29
30	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	755	755	30
31	V								31
32	V	19	HOME OFFICE	588,900	DYNAMIC HEALTH CARE CONS.	100.00%		(588,900)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 588,900			$ 155,329	$ * (433,571)	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 6,402	$ 6,402	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	19,246	19,246	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	21,952	21,952	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	500	500	18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	22,618	22,618	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	16,188	16,188	24
25	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	12,802	12,802	26
27	V	17	ADMIN. CMP. - A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	20,338	20,338	28
29	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	23,608	23,608	29
30	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	8,568	8,568	30
31	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	602	602	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 152,824	$ * 152,824	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: 01/01/16 Ending: 12/31/16

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%	$ 664	$ 664	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	3,992	3,992	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	4,161	4,161	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,947	7,947	18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,885	1,885	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27	EMP. BEN.- B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	1,139	1,139	24
25	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	3,234	3,234	26
27	V	27	EMP. BEN.-A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	5,754	5,754	28
29	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,480	2,480	29
30	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,763	1,763	30
31	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	371	371	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 33,390	$ * 33,390	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	13.10%	BRIDGEVIEW HEALTH CARE CENTER, LTD	BRIDGEVIEW	WILLOW CREST BUILDING COMPANY		BUILDING CO.	1
2	MAURICE I. AARON	23.79%	GROSSE POINTE MANOR, LLC	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULTING	2
3	SHIMON GOLDSTEIN	21.55%	OTTAWA PAVILION, LTD	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MIRIAM LATINIK	4.31%	PARK RIDGE CARE CENTER LTD	PARK RIDGE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	4
5	MARSHALL A MAUER	10.78%	STERLING PAVILION	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	5
6	SHARON S. AARON	0.56%	WATERFRONT TERRACE, INC	CHICAGO				6
7	CHANI MAUER	6.05%	WILLOW CREST NURSING PAVILION, LTD	SANDWICH				7
8	DENNIS NEHMER	0.56%	WINDMILL NURSING PAVILION, LTD	SOUTH HOLLAND				8
9	ESTHER MARYLES	6.05%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG	GALESBURG				9
10	HOWIE & SUSIE ALTER	1.12%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO SL	GENESEO				10
11	SYLVIA AARON	0.22%	WOODBRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC SLI	PONTIAC				11
12	SUSAN KOPLIN	0.56%	WOODBRIDGE NURSING PAVILION	CHICAGO				12
13	DIANIA KUFTA	0.56%	RIVER NORTH OF BRADLEY	BRADLEY				13
14	FRANCES MAUER	10.78%						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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Shareholder	Administrative	10.78%	See Attached	3.85	7.70%	Alloc. Salary	$ 19,246	17-07	1
2	Maury Aaron	Shareholder	Administrative	23.79%	See Attached	4.39	8.78%	Alloc. Salary	21,952	17-07	2
3	Daniel Aaron	Relative	Administrative	0%	See Attached	11.82	29.55%	Alloc. Salary	22,618	17-07	3
4	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9	20.00%	Sal/Alloc. Sal	42,500	17-01/17-07	4
5	Esther Maryles	Shareholder	Clerical	6.05%	See Attached	0.27	0.96%	Alloc. Salary	602	21-07	5
6	Sharon Aaron	Shareholder	Clerical	0.56%	See Attached	3.85	9.63%	Alloc. Salary	8,568	21-07	6
7	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	4.39	10.98%	Alloc. Salary	6,402	06-07	7
8	Diania Kufta	Shareholder	Administrative	0.56%	See Attached	5.49	10.98%	Alloc. Salary	16,188	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	$ 138,076		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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	415,748	13	$ 10,619	$	38,046	$ 972	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	415,748	13	67,972	32,339	38,046	6,220	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	415,748	13	2,182		38,046	200	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	13	59,702		38,046	5,463	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	415,748	13	17,185		38,046	1,573	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	13	1,068,604	741,401	38,046	97,790	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	13	19,810		38,046	1,813	7
8	25	AUTO EXP.	PATIENT DAYS	415,748	13	16,560		38,046	1,515	8
9	26	INSURANCE	PATIENT DAYS	415,748	13	31,660		38,046	2,897	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	415,748	13	178,906		38,046	16,372	10
11	30	DEPRECIATION	PATIENT DAYS	415,748	13	28,663		38,046	2,623	11
12	32	INTEREST	PATIENT DAYS	415,748	13	24,945		38,046	2,283	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	13	41,869		38,046	3,832	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	415,748	13			38,046		14
15	35	AUTO RENTAL	PATIENT DAYS	415,748	13	120,431		38,046	11,021	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	13	8,254		38,046	755	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,697,362	$ 773,741		$ 155,329	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	58,328	58,328	4	6,402	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	4	19,246	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	4	21,952	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	2,500	2,500	9	500	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	76,541	76,541	12	22,618	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	182,833	182,833			6
7	17	ADMIN. CMP. - B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	200,000	200,000			7
8	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	60,541	60,541			8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	72,895	72,895			9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	147,459	5	16,188	10
11	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000			11
12	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	10	133,035	133,035	4	12,802	12
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	94,167	94,167			13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	185,179	185,179	5	20,338	14
15	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	40	10	245,335	245,335	4	23,608	15
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	89,040	89,040	4	8,568	16
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	62,541	62,541	0	602	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,022,394	$ 2,022,394		$ 152,824	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.

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Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
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	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	6,047		4	664	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	41,488		4	3,992	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	37,909		4	4,161	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,733		9	7,947	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	6,379		12	1,885	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	36,760				6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,395				7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	4,779				8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,583				9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,371		5	1,139	10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,060				11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	33,608		4	3,234	12
13	27	EMP. BEN.-A. CASSATA (NON-(	WGHTD. AVG. HOURS	40	1	7,352				13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	52,388		5	5,754	14
15	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	10	25,777		4	2,480	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	18,319		4	1,763	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	38,523		0	371	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 398,471	$		$ 33,390	25

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 7,974,413			$ 321,916	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				750,000			31,276	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 8,724,413			$ 353,192	9
	B. Non-Facility Related*											
10	Interest Income		X								(44,369)	10
11	Interest Income - Bldg. Co.		X								(337)	11
12	Allocated - Dynamic HC	X									2,283	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (42,423)	14
15	TOTALS (line 9+line14)						$	$ 8,724,413			$ 310,769	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 52,303 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: 01/01/16 Ending: 12/31/16

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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 42,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 45,881	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,881	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 46,881	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	40,746	8
	2012	41,732	9
	2013	40,582	10
	2014	41,575	11
	2015	42,049	12

2016 Accrual = $42,049 x 1.02 = $43,000 (Rounded)

Allocated - Dynamic HC Consultants - $3,832

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 42,048.76	$ 42,048.76
2.	10-23-404-059-0000	Allocated - Dynamic HC	$ 40,971.35	$ 3,749.38
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,020.11	$ 45,798.14

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	$ 145,578	39	$ 65,250	$ (80,328)	$ 1,174,219	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			8,310	13
14	Various			1995	3,234		20			3,234	14
15	Various			1996	17,411		20	720	720	17,406	15
16	Various			1997	68,499		20	3,425	3,425	65,189	16
17	Various			1998	31,645		20	1,582	1,582	29,596	17
18	Various			1999	147,088		20	7,297	7,297	127,517	18
19	Various			2000	149,982		20	7,499	7,499	124,115	19
20	Various			2001	139,226		20	6,961	6,961	107,470	20
21	Various			2002	52,106		20	159	159	51,247	21
22	Various			2003	79,602		20			79,602	22
23	Various			2004	54,194		20			54,194	23
24	Various			2005	41,185		20			41,185	24
25	Various			2006	24,334		20	732	732	24,334	25
26	Various			2007	36,779		20	2,982	2,982	33,531	26
27	Various			2008	74,672		20	4,358	4,358	69,063	27
28	Various			2009	29,315		20	387	387	16,938	28
29	Various			2010	48,685		20	2,027	2,027	13,078	29
30	Various			2011	36,523		20	2,918	2,918	16,318	30
31	Various			2012	137,257		20	25,007	25,007	110,915	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: 01/01/16 Ending: 12/31/16

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
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		490,154			24,508	24,508	47,000	67
68	Related Party Allocations (Pages 12H & 12I)		40,595	1,041		1,160	119	27,063	68
69	Financial Statement Depreciation			170,157			(170,157)		69
70	TOTAL (lines 4 thru 69)		$ 4,318,086	$ 316,776		$ 156,971	$ (159,805)	$ 2,303,993	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: 01/01/16 Ending: 12/31/16

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		$ 4,318,086	$ 316,776		$ 156,971	$ (159,805)	$ 2,303,993	1
2	Elevator Work	2013	2,560		20	128	128	501	2
3	Installed New Hydraulic Oil In Elevators	2013	8,155		20	408	408	1,597	3
4	Resident Bathroom Countertops - 2Nd Floor	2013	4,596		20	118	118	447	4
5	Bathroom Trim Molding, Mirror, Grout, Light Fixtures - 2Nd Flo	2013	4,473		20	895	895	3,429	5
6	Smoke Alarm, Safety Guard, Bathroom Lock, Plumbing - 2Nd Flo	2013	3,324		20	665	665	2,493	6
7	Light Fixtures In Resident Rooms - 2Nd Floor	2013	7,699		20	1,540	1,540	5,774	7
8	New Grease Trap In Kitchen	2013	6,073		20	156	156	564	8
9	Build Out Kitchen And Install Grease Traps	2013	11,804		20	303	303	1,047	9
10	Woodframes And Boards For Flooring - 2Nd Floor	2013	7,746		20	199	199	687	10
11	Light Fixtures, Curtains, Window Treatments, Floor - 2Nd Floor	2013	67,805		20	13,561	13,561	47,463	11
12	Install Carpet Covering - 2Nd Floor	2013	8,208		20	1,642	1,642	5,608	12
13	Fixture & Lighting - 2Nd Floor	2013	4,972		20	994	994	3,398	13
14	Outlets For 1St Floor	2013	4,072		20	814	814	2,646	14
15	Security Equip	2013	2,895		20	579	579	1,882	15
16	Security Equip	2013	3,395		20	679	679	2,150	16
17	Molding, Towel Bars For First Floor Bathrooms	2013	10,408		20	2,082	2,082	6,418	17
18	Rewired Indicating Circuits & Installed New Fire Alarm System D	2014	4,950		20	707	707	1,886	18
19	1St Floor Bathroom Piping, Tile Drywall, Outlets, Paint, Lights, T	2014	6,997		20	350	350	933	19
20	1St Floor Countertops & Shelving	2014	19,084		20	954	954	2,545	20
21	1St Floor Flooring	2014	11,689		20	584	584	1,559	21
22	Gasket - Gear Housing Adapter For Generator	2016	2,887		20	69	69	69	22
23	Video Monitoring System	2016	3,182		20	477	477	477	23
24	First Floor Dining Room Window Treatments	2016	2,548		20	382	382	382	24
25	Installed Holding Tank For Boiler	2016	3,419		20	33	33	33	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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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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)		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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: 01/01/16 Ending: 12/31/16

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		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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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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)		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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: 01/01/16 Ending: 12/31/16

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		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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)		$ 4,531,026	$ 316,776		$ 185,288	$ (131,488)	$ 2,397,982	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: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	First Floor Bathrooms Remodeling - Tile, Fixtures, Counter Tops	2015	27,461		20	1,373	1,373	2,746	9
10	First Floor Carpeting	2015	11,689		20	584	584	1,169	10
11	First Floor Corridor - Wall Coverings, Ceiling Tile, Light Fixtures	2015	101,128		20	5,056	5,056	10,113	11
12	Front Entrance - Windows, Roof, Sprinkler, and Gutters	2015	108,854		20	5,443	5,443	10,885	12
13	Installed Wall Coverings in Offices	2015	19,776		20	989	989	1,978	13
14	Poured Sidewalk	2015	7,052		20	353	353	705	14
15	Construction of Seatwall and Pillars with lights, and Patio	2015	27,135		20	1,357	1,357	2,714	15
16	Landscaping	2015	3,874		20	194	194	387	16
17	New Heating Unit and Duct Work	2015	7,384		20	369	369	738	17
18	Installed Window Treatments	2015	27,859		20	1,393	1,393	2,786	18
19	Custom Nursing Stations	2015	34,379		20	1,719	1,719	3,438	19
20	Wall Covering in Office and Corridor and 30 Corner Guards	2015	29,306		20	1,465	1,465	2,931	20
21	Signage for Corridor and Reception Area	2015	9,825		20	491	491	982	21
22	Dining Room Light Fixtures and Flooring	2015	20,242		20	1,012	1,012	2,024	22
23	First Floor Resident Rooms Light Fixtures	2015	4,916		20	246	246	492	23
24	Dining Room Corner Guards	2015	2,967		20	148	148	297	24
25	Installed 6 Windows	2015	6,000		20	300	300	600	25
26	69 Aluminum Siding Insulated Windows	2016	20,209		20	1,010	1,010	1,010	26
27	Kitchen Cabinetry for First Floor Dining Room	2016	3,288		20	164	164	164	27
28	Eleven Drop Sprinkler Heads to New Framework of Ceiling	2016	6,470		20	324	324	324	28
29	Flooring for Resident Rooms	2016	5,960		20	298	298	298	29
30	New Drywall for First Floor Dining Room	2016	4,380		20	219	219	219	30
31					20				31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 490,154	$		$ 24,508	$ 24,508	$ 47,000	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: 01/01/16 Ending: 12/31/16

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		$ 490,154	$		$ 24,508	$ 24,508	$ 47,000	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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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)		$ 490,154	$		$ 24,508	$ 24,508	$ 47,000	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: 01/01/16 Ending: 12/31/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - Dynamic HC Consultants	1993	40,595	1,041	35	1,160	119	27,063	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		$ 40,595	$ 1,041		$ 1,160	$ 119	$ 27,063	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: 01/01/16 Ending: 12/31/16

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		$ 40,595	$ 1,041		$ 1,160	$ 119	$ 27,063	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 40,595	$ 1,041		$ 1,160	$ 119	$ 27,063	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: 01/01/16 Ending: 12/31/16

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	$ 625,965	$ 587	$ 73,395	$ 72,808	10	$ 486,205	71
72	Current Year Purchases	129,358		12,596	12,596	10	7,242	72
73	Fully Depreciated Assets	1,013,416		262	262	10	1,013,326	73
74								74
75	TOTALS	$ 1,768,739	$ 587	$ 86,253	$ 85,666		$ 1,506,772	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 Consulta	2005	27,091	995	2,457	1,462	5	2,457	78
79										79
80	TOTALS			$ 87,671	$ 995	$ 2,457	$ 1,462		$ 63,037	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)	$ 6,715,295	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 318,358	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 273,998	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,360)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,967,791	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	$ 14,965	92
93			93
94			94
95		$ 14,965	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: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 10,195 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	2015 Ford Starcraft	$ 733	$ 8,796	17
18	Allocated - Dynamic HC Consultants			11,021	18
19					19
20					20
21	TOTAL		$ 733	$ 19,817	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: 01/01/16 Ending: 12/31/16

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 201,718		$	$		$ 201,718	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	68,299					68,299	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	190,908					190,908	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				210,864		210,864	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						24,225		24,225	13
14	TOTAL			$ 460,925		$	$ 235,089		$ 696,014	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 Willow Crest Nrsing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 77,524	$ 312,964	1
2	Cash-Patient Deposits	39,108	39,108	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,760,869	1,760,869	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,385	110,091	6
7	Other Prepaid Expenses	102,295	102,295	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	75,850	394,590	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,147,031	$ 2,719,917	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	1,538,189	1,917,651	15
16	Equipment, at Historical Cost	1,368,580	1,962,690	16
17	Accumulated Depreciation (book methods)	(2,387,716)	(4,118,038)	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)	(20,406)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	804,371	804,371	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,323,424	$ 3,582,011	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,470,455	$ 6,301,928	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 554,570	$ 569,535	26
27	Officer's Accounts Payable		3,034	27
28	Accounts Payable-Patient Deposits	39,108	39,108	28
29	Short-Term Notes Payable	750,000	914,187	29
30	Accrued Salaries Payable	319,937	319,937	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,282	5,282	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,000	32
33	Accrued Interest Payable	1,536	28,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	15,412	15,412	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	78,000	78,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,763,845	$ 2,015,612	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,810,226	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)**	$	$ 7,810,226	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,763,845	$ 9,825,838	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,706,610	$ (3,523,910)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,470,455	$ 6,301,928	48

***(See instructions.)**

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,590,931	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,590,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	254,879	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)**	$ 115,679	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,706,610	24 *

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 8,229,533	1
2	Discounts and Allowances for all Levels	(2,007,297)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,222,236	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,772,970	6
7	Oxygen	1,823	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,774,793	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	304,084	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,686	19
20	Radiology and X-Ray	7,380	20
21	Other Medical Services	17,940	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 380,090	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,369	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,369	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	121,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 121,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,542,488	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,382	31
32	Health Care	2,693,614	32
33	General Administration	2,123,125	33
	B. Capital Expense		
34	Ownership	1,299,222	34
	C. Ancillary Expense		
35	Special Cost Centers	766,961	35
36	Provider Participation Fee	256,305	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,287,609	40
41	**Income before Income Taxes (line 30 minus line 40)****	254,879	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 254,879	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,531,833	44
45	Private Pay - Net Inpatient Revenue	1,271,362	45
46	Medicare - Net Inpatient Revenue	1,216,631	46
47	Other-(specify) Hospice	202,410	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,222,236	49

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

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

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

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

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2,415	2,807	$ 128,767	$ 45.87	1
2	Assistant Director of Nursing	2,018	2,194	72,861	33.21	2
3	Registered Nurses	14,691	15,495	482,414	31.13	3
4	Licensed Practical Nurses	22,288	23,593	668,631	28.34	4
5	CNAs & Orderlies	64,898	68,859	838,382	12.18	5
6	CNA Trainees					6
7	Licensed Therapist	10,231	10,918	460,925	42.22	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,423	2,655	68,819	25.92	9
10	Activity Assistants	12,966	14,402	139,371	9.68	10
11	Social Service Workers	1,927	2,063	37,104	17.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,128	63,515	29.85	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,252	2,548	154,624	60.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,261	8,105	135,812	16.76	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	1,250	1,538	30,271	19.68	31
32	Other Health Care(specify)					32
33	Other(specify)	5,406	5,588	107,189	19.18	33
34	TOTAL (lines 1 - 33)	152,050	162,893	$ 3,388,685 *	$ 20.80	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	120	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed	8,127	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	39	2,035	11-03	44
45	Social Service Consultant	70	5,247	12-03	45
46	Other(specify)				46
47	Outside Dietary Services		403,466	01-03	47
48					48
49	TOTAL (lines 35 - 48)	229	$ 430,875		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: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator		$ 112,624
Fred Aaron	Administrative	13.10%	42,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,624

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
Health Data Systems	Clinical / E.H.R.	$ 12,880
Dynamic HC Consultants	Bookkeeping / Home Office	588,900
Personnel Planners	Unemployment Consulting	762
Marcum	Accounting	28,132
Casamba	EMR for Therapy	4,200
Wescom Solutions	E.H.R.	33,030
National Datacare Corporation	Data Processing	4,002
Dynamic HC Consultants	Data Processing	10,804
eHealth Data Solutions	Risk Management Software	4,093
NTT Data LTC Solutions	Data Processing	6,338
Legal	See Attached	14,936
See Supplemental Schedule		579
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 708,655

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,557
Unemployment Compensation Insurance	39,733
FICA Taxes	254,400
Employee Health Insurance	186,386
Employee Meals	12,938
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	16,797
TOTAL (agree to Schedule V, line 22, col.8)	$ 578,812

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	50,340
Health Care Worker Background Check	2,761
(Indicate # of checks performed 276)	
Patient Background Checks	
Licenses and Permits	8,518
Dues and Subscriptions	12,755
Allocated - Dynamic HC Consultants	1,573
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,630
Allocated - Dynamic HC Consultants	1,813
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,443

**See instructions.

Facility Name & ID Number Willow Crest Nrsing Pavilion # 0036533 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $17,041**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **79** Line **10**

(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 fo
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 Departmen
during this cost report period. $ **256,305**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **12,938** 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 fo
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 1**
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