FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 NURSING PAVILION

Address: 515 NORTH MAIN (Number) SANDWICH (City) 60548 (Zip Code)

County: DEKALB

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

HFS ID Number:

Date of Initial License for Current Owners: 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: KATHLEEN MCNAMARA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	8	Intermediate (ICF)	8	2,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,305	9,483	6,142	32,930	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,305	9,483	6,142	32,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.78%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 08/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 105 and days of care provided 5,800

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		1,677	588,939	590,616		590,616	(1,349)	589,267			1
2	Food Purchase											2
3	Housekeeping	189		182,959	183,148		183,148		183,148			3
4	Laundry		9,357	118,682	128,039		128,039		128,039			4
5	Heat and Other Utilities			111,347	111,347		111,347	1,165	112,512			5
6	Maintenance	66,168	88,932	40,322	195,422		195,422	16,166	211,588			6
7	Other (specify):*			8,506	8,506		8,506	793	9,299			7
8	**TOTAL General Services**	66,357	99,966	1,050,755	1,217,078		1,217,078	16,775	1,233,853			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,110,411	108,304	86,774	2,305,489		2,305,489		2,305,489			10
10a	Therapy	58,653	11,032		69,685		69,685		69,685			10a
11	Activities	219,397	14,717	3,834	237,948		237,948		237,948			11
12	Social Services	46,636		2,640	49,276		49,276		49,276			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,435,097	134,053	105,248	2,674,398		2,674,398		2,674,398			16
	C. General Administration											
17	Administrative	94,498			94,498		94,498	162,384	256,882			17
18	Directors Fees											18
19	Professional Services			137,206	137,206		137,206	(3,084)	134,122			19
20	Dues, Fees, Subscriptions & Promotions			149,626	149,626		149,626	(67,303)	82,323			20
21	Clerical & General Office Expenses	304,660	25,356	613,203	943,219		943,219	(569,397)	373,822			21
22	Employee Benefits & Payroll Taxes			535,000	535,000		535,000		535,000			22
23	Inservice Training & Education			4,833	4,833		4,833		4,833			23
24	Travel and Seminar							542	542			24
25	Other Admin. Staff Transportation			18,142	18,142		18,142	(2,311)	15,831			25
26	Insurance-Prop.Liab.Malpractice			185,561	185,561		185,561	10,651	196,212			26
27	Other (specify):*			124,055	124,055		124,055	(60,448)	63,607			27
28	**TOTAL General Administration**	399,158	25,356	1,767,626	2,192,140		2,192,140	(528,966)	1,663,174			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,900,612	259,375	2,923,629	6,083,616		6,083,616	(512,191)	5,571,425			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#: WILLOW CREST NURSING PAVILION #0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2		
	REPAIRS & MAINTENANCE			
	CONTRACT DIETARY		588,939	588,939
3	**HOUSEKEEPING**			
	CONTRACT HOUSEKEEPING		182,959	
				182,959
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,549	
	CONTRACT LAUNDRY		115,133	118,682
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		10,990	
	ELECTRICITY		74,831	
	WATER		18,236	
	CABLE TV - LOBBY		7,290	
				111,347
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		12,653	
	PAINTING & DECORATING		894	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		16,716	
	ELEVATOR MAINTENANCE & REPAIR		9,884	
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		175	
	FIRE SERVICE			
				40,322
7	**OTHER**			
	SCAVENGER		8,506	
	SECURITY SERVICE			
				8,506
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	28,052	
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	18,387	
	PHARMACY CONSULTANT	XVIII B 39-2	15,576	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	24,759	
				86,774
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,834	
				3,834
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	SOCIAL WORKER	XVIII B 45-2	2,640	
				2,640
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number WILLOW CREST NURSING PAVILION **#0036533** **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION			
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B		0
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	80,567	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	56,639	
				137,206
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	59,202	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	55,537	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	11,902	
	LICENSES & PERMITS	XIX F	10,090	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,290	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	227	
	PATIENT BACKGROUND CHECKS	XIX F	2,378	
				149,626
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,213	
	EQUIPMENT REPAIR & MAINTENANCE		28,127	
	OUTSIDE CLERICAL SERVICES		563,523	
	PENALTIES / OVERDRAFT CHARGES	VI 18	25	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		14,315	
	MESSENGER SERVICE			
				613,203

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	252,928	
	UNEMPLOYMENT COMPENSATION	XIX D	29,422	
	WORKERS COMPENSATION INSURANC	XIX D	85,542	
	HOSPITALIZATION INSURANCE	XIX D	143,053	
	EMPLOYEE BENEFITS - OTHER	XIX D	24,055	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				535,000
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,833	
				4,833
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G		
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,142	
				18,142
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		185,561	
				185,561
27	**OTHER**			
	BAD DEBTS	VI 24	124,055	
				124,055

GRAND TOTAL COLUMN 3 OTHER **2,923,629**

WILLOW CREST NURSING PAVILION
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	0
LESS SALES TAX	(1,349)
NET FOOD	(1,349)
TOTAL PATIENT CENSUS	32,930
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	98,790
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	39,420
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	98,790
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	98,790
NET FOOD	-1,349
DIVIDE TOTAL MEALS/YEAR	98,790
COST PER MEAL	-0.01
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFIC	**0**

Facility Name & ID Number WILLOW CREST NURSING PAVILION #0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			90,134	90,134		90,134	155,293	245,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,152	44,152		44,152	271,490	315,642			32
33	Real Estate Taxes							49,866	49,866			33
34	Rent-Facility & Grounds			1,074,000	1,074,000		1,074,000	(1,074,000)				34
35	Rent-Equipment & Vehicles			62,981	62,981		62,981	10,852	73,833			35
36	Other (specify):* STORAGE							50,391	50,391			36
37	**TOTAL Ownership**			1,271,267	1,271,267		1,271,267	(536,108)	735,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	486,218	217,677		703,895		703,895		703,895			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,952	226,952		226,952		226,952			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	486,218	217,677	226,952	930,847		930,847		930,847			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,386,830	477,052	4,421,848	8,285,730		8,285,730	(1,048,299)	7,237,431			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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(3,006)	30		9
10	Interest and Other Investment Income	(39,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,349)	1		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	(25)	21		18
19	Entertainment				19
20	Contributions	(10,290)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,697)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,055)	27		24
25	Fund Raising, Advertising and Promotional	(59,202)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule 5A	(150,364)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (394,062)		$	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)			34
35	Other- Attach Schedule	(654,237)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (654,237)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,048,299)		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

STATE OF ILLINOIS

WILLOW CREST NURSING PAVILION

ID# 0036533

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (94,455)	21	1
2	Bank Charges	(7,213)	21	2
3	BUILDING CO -STATE REPLACEMENT TAX	(6,783)	21	3
4	BUILDING CO -PROFESSIONAL FEES	(28,361)	19	4
5	BUILDING CO -AMORTIZATION	(5,238)	32	5
6	BUILDING CO- INTEREST INCOME	(331)	32	6
7	Marketing Transportation	(6,629)	25	7
8	Non allowable Transportation	(1,354)	25	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(150,364)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(1,349)	0	0	0	0	0	0	0	0	0	0	(1,349)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,165	0	0	0	0	0	0	0	0	1,165	5
6	Maintenance	0	0	6,517	9,649	0	0	0	0	0	0	0	16,166	6
7	Other (specify):*	0	0	793	0	0	0	0	0	0	0	0	793	7
8	TOTAL General Services	(1,349)	0	8,475	9,649	0	0	0	0	0	0	0	16,775	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	162,384	0	0	0	0	0	0	0	162,384	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,058)	28,361	3,613	0	0	0	0	0	0	0	0	(3,084)	19
20	Fees, Subscriptions & Promotions	(69,492)	0	2,189	0	0	0	0	0	0	0	0	(67,303)	20
21	Clerical & General Office Expenses	(108,476)	6,783	(477,837)	10,133	0	0	0	0	0	0	0	(569,397)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	542	0	0	0	0	0	0	0	0	542	24
25	Other Admin. Staff Transportation	(7,983)	0	5,672	0	0	0	0	0	0	0	0	(2,311)	25
26	Insurance-Prop.Liab.Malpractice	0	5,648	5,003	0	0	0	0	0	0	0	0	10,651	26
27	Other (specify):*	(124,055)	0	63,607	0	0	0	0	0	0	0	0	(60,448)	27
28	TOTAL General Administration	(345,064)	40,792	(397,211)	172,517	0	0	0	0	0	0	0	(528,966)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(346,413)	40,792	(388,736)	182,166	0	0	0	0	0	0	0	(512,191)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(3,006)	155,878	2,421	0	0	0	0	0	0	0	0	155,293	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44,643)	313,967	2,166	0	0	0	0	0	0	0	0	271,490	32
33	Real Estate Taxes	0	45,198	4,668	0	0	0	0	0	0	0	0	49,866	33
34	Rent-Facility & Grounds	0	(1,074,000)	0	0	0	0	0	0	0	0	0	(1,074,000)	34
35	Rent-Equipment & Vehicles	0	0	10,852	0	0	0	0	0	0	0	0	10,852	35
36	Other (specify):*	0	50,391	0	0	0	0	0	0	0	0	0	50,391	36
37	TOTAL Ownership	(47,649)	(508,566)	20,107	0	0	0	0	0	0	0	0	(536,108)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(394,062)	(467,774)	(368,629)	182,166	0	0	0	0	0	0	0	(1,048,299)	45

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,074,000	Willow Crest Building LLC	100.00%	$	$ (1,074,000)	1
2	V	32	Interest		Willow Crest Building LLC	100.00%	308,729	308,729	2
3	V	21	State Replacement Tax		Willow Crest Building LLC	100.00%	6,783	6,783	3
4	V	19	Professional fees		Willow Crest Building LLC	100.00%	28,361	28,361	4
5	V	33	Real Estate Tax		Willow Crest Building LLC	100.00%	45,198	45,198	5
6	V	26	Insurance		Willow Crest Building LLC	100.00%	5,648	5,648	6
7	V	36	MIP Expense		Willow Crest Building LLC	100.00%	50,391	50,391	7
8	V	30	Depreciation		Willow Crest Building LLC	100.00%	155,878	155,878	8
9	V	32	Amortization		Willow Crest Building LLC	100.00%	5,238	5,238	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,000			$ 606,226	$ * (467,774)	14

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	21	HOME OFFICE	$ 563,523	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (563,523)	15
16	V	5	UTILITIES		DYNAMIC HEALTHCARE CONSULTANTS		1,165	1,165	16
17	V	6	REPAIR & MAINT. - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS		1,386	1,386	17
18	V	6	REPAIR & MAINT.-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		5,131	5,131	18
19	V	7	EMP BEN-GEN SERV		DYNAMIC HEALTHCARE CONSULTANTS		793	793	19
20	V	19	PROFESSIONAL FEES		DYNAMIC HEALTHCARE CONSULTANTS		3,613	3,613	20
21	V	20	DUES AND SUBSCRIPTION		DYNAMIC HEALTHCARE CONSULTANTS		2,189	2,189	21
22	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS		63,451	63,451	22
23	V	21	CLERICAL & GENERAL-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		22,235	22,235	23
24	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTHCARE CONSULTANTS		542	542	24
25	V	25	AUTO EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS		5,672	5,672	25
26	V	26	INSURANCE		DYNAMIC HEALTHCARE CONSULTANTS		5,003	5,003	26
27	V	27	EMP. BEN. - GEN, ADMIN.		DYNAMIC HEALTHCARE CONSULTANTS		63,607	63,607	27
28	V	30	DEPRECIATION		DYNAMIC HEALTHCARE CONSULTANTS		2,421	2,421	28
29	V	32	INTEREST		DYNAMIC HEALTHCARE CONSULTANTS		2,166	2,166	29
30	V	33	REAL ESTATE TAXES		DYNAMIC HEALTHCARE CONSULTANTS		4,668	4,668	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTHCARE CONSULTANTS		10,203	10,203	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTHCARE CONSULTANTS		649	649	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 563,523			$ 194,894	$ * (368,629)	39

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 9,649	$ 9,649	15
16	V	17	ADMIN COMP - M MAUER		DYNAMIC HEALTHCARE CONSULTANTS		24,900	24,900	16
17	V	17	ADMIN COMP - M AARON		DYNAMIC HEALTHCARE CONSULTANTS		31,600	31,600	17
18	V	17	ADMIN COMP - F AARON		DYNAMIC HEALTHCARE CONSULTANTS		806	806	18
19	V	17	ADMIN COMP - D AARON		DYNAMIC HEALTHCARE CONSULTANTS		9,542	9,542	19
20	V	17	ADMIN COMP - S GOLDSTEIN		DYNAMIC HEALTHCARE CONSULTANTS				20
21	V	17	ADMIN COMP - R AARON		DYNAMIC HEALTHCARE CONSULTANTS		8,450	8,450	21
22	V	17	ADMIN COMP - S HARAMARAS		DYNAMIC HEALTHCARE CONSULTANTS				22
23	V	17	ADMIN COMP - D KUFTA		DYNAMIC HEALTHCARE CONSULTANTS		24,730	24,730	23
24	V	17	ADMIN COMP - HOWARD ALTER		DYNAMIC HEALTHCARE CONSULTANTS				24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS		DYNAMIC HEALTHCARE CONSULTANTS		16,609	16,609	25
26	V	17	ADMIN COMP - VAR NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS		5,768	5,768	26
27	V	17	ADMIN COMP - CFO NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS		27,158	27,158	27
28	V	17	ADMIN COMP - CONTROLLER-NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS		12,821	12,821	28
29	V	21	CLERICAL COMP - S AARON		DYNAMIC HEALTHCARE CONSULTANTS		10,133	10,133	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			$			$ 182,166	$ * 182,166	39

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Aaron	13.10%	Bridgeview Health Care Center	Bridgeview	Willow Crest Building Company		Building Company	1
2	Maurice Aaron	23.79%	Grosse Pointe Manor	Niles	Dynamic Healthcare	Skokie	Bookkeeping/Consu	2
3	Shimon Goldstein	21.55%	Ottawa Pavillion Ltd	Ottawa	Seasons Hospice	Park Ridge	Hospice	3
4	Miriam Latinik	4.31%	Park Ridge Care Center Ltd	Park Ridge	Integra Healthcare	Elmhurst	DME	4
5	Marshall Mauer	10.78%	Sterling Pavilion Ltd	Sterling	Lifeline Ambulance	Chicago	Ambulance	5
6	Sharon Aaron	0.56%	Waterfront Terrace Inc	Chicago				6
7	Chani Mauer	6.05%	Windmill Nursing Pavilion Ltd	South Holland				7
8	Dennis Nehmer	0.56%	Woodbridge Nursing Pavilion Ltd	Chicago				8
9	Esther Maryles	6.05%	Woodbridge Supportive Living Residence of Ga	Galesberg				9
10	Susie and Howie Alter	1.12%	Woodbridge Supportive Living Residence of Ga	Galesberg				10
11	Sylvia Aaron	0.22%	The Loft Rehabilitation & Nursing	Eureka				11
12	Sue Koplin	0.56%	The Loft Rehabilitation & Nursing of Canton	Canton				12
13	Diania Kufta	0.56%	The Loft Rehabilitation & Nursing of Normal	Normal				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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	$ 24,900	17-07	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	31,600	17-07	2
3	DANIEL AARON	RELATIVE	ADMINISTRATIVE		SEE ATTACHED			SALARY	9,542	17-07	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	806	17-07	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	42,000	21-01	5
6	SHARON AARON	SHAREHOLDER	CLERICAL		SEE ATTACHED			SALARY	10,133	21-07	6
7	DENNIS NEHMER	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	9,649	06-07	7
8	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIVE		SEE ATTACHED			SALARY	24,730	17-07	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 153,360		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	302,492	10	$ 10,544	$	33,430	$ 1,165	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	302,492	10	12,541	12,541	33,430	1,386	2
3	6	REPAIR & MAINT.-OTHER EXPE	PATIENT DAYS	302,492	10	46,430		33,430	5,131	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	302,492	10	7,174		33,430	793	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	302,492	10	32,693		33,430	3,613	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	302,492	10	19,807		33,430	2,189	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	302,492	10	574,139	574,139	33,430	63,451	7
8	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	302,492	10	201,196		33,430	22,235	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	302,492	10	4,903		33,430	542	9
10	25	AUTO EXPENSE	PATIENT DAYS	302,492	10	51,327		33,430	5,672	10
11	26	INSURANCE	PATIENT DAYS	302,492	10	45,267		33,430	5,003	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	302,492	10	575,549		33,430	63,607	12
13	30	DEPRECIATION	PATIENT DAYS	302,492	10	21,903		33,430	2,421	13
14	32	INTEREST	PATIENT DAYS	302,492	10	19,599		33,430	2,166	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	302,492	10	42,234		33,430	4,668	15
16	35	AUTO RENTAL	PATIENT DAYS	302,492	10	92,319		33,430	10,203	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	302,492	10	5,875		33,430	649	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,763,500	$ 586,680		$ 194,894	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	7	$ 60,778	$ 60,778	6	$ 9,649	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	5	24,900	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000	6	31,600	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500	15	806	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	30	10	76,541	76,541	4	9,542	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	159,922	159,922			6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	30	5	26,000	26,000	10	8,450	7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	156,522	156,522	6	24,730	9
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	9	132,083	132,083	5	16,609	11
12	17	ADMIN COMP - VAR NON OWNEI	WGHTD AVG HOURS	45	7	36,458	36,458	7	5,768	12
13	17	ADMIN COMP - CFO NON OWNEI	WGHTD AVG HOURS	40	9	215,972	215,972	5	27,158	13
14	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	101,958	101,958	5	12,821	14
15	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	80,583	80,583	5	10,133	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,530,328	$ 1,530,328		$ 182,166	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			$	$ 7,639,350			$ 308,729	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mb Financial		x	Line of Credit							44,152	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,639,350			$ 352,881	9
	B. Non-Facility Related*											
10	Interest Income		x								(39,074)	10
11	Dynamic alloc	x									2,166	11
12	Interest Bldg Co		x								(331)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (37,239)	14
15	TOTALS (line 9+line14)						$	$ 7,639,350			$ 315,642	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 50,391 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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	46,500	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.)	$	50,066	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,566	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,300	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.	$	49,866	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	40,582	8
	2014	41,575	9
	2015	42,049	10
	2016	45,325	11
	2017	45,398	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW CREST NURSING PAVILION COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 45,398.32	$ 45,398.32
2.	10-23-404-059-0000	Allocated - Dynamic Hc	$ 42,234.00	$ 4,668.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,632.32	$ 50,066.32

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 155,878	39	$ 65,250	$ (90,628)	$ 1,304,719	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20			21,410	9
10	Various			1991	9,997		20			9,997	10
11	Various			1992	4,279		20			4,279	11
12	Various			1994	8,312		20			8,312	12
13	Various			1995	3,234		20			3,234	13
14	Various			1996	17,411		20			17,411	14
15	Various			1997	63,316		20			63,316	15
16	Various			1998	31,645		20	467	467	31,645	16
17	Various			1999	137,772		20	6,831	6,831	132,832	17
18	Various			2000	149,982		20	7,499	7,499	139,113	18
19	Various			2001	127,742		20	6,387	6,387	111,283	19
20	Various			2002	52,106		20	159	159	51,564	20
21	Various			2003	77,352		20			77,352	21
22	Various			2004	51,944		20			51,944	22
23	Various			2005	41,185		20			41,185	23
24	Various			2006	24,334		20			24,334	24
25	Various			2007	36,779		20	1,777	1,777	38,556	25
26	Various			2008	74,672		20	4,358	4,358	77,778	26
27	Various			2009	29,315		20	387	387	17,712	27
28	Various			2010	48,685		20	2,027	2,027	17,131	28
29	Various			2011	36,459		20	2,918	2,918	22,154	29
30	Various			2012	137,257		20	14,244	14,244	139,403	30
31	Various			2013	147,694		20	24,197	24,197	132,339	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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									67
68									68
69	Financial Statement Depreciation			90,134			(90,134)		69
70	TOTAL (lines 4 thru 69)		$ 3,877,615	$ 246,012		$ 136,501	$ (109,511)	$ 2,539,003	70

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,877,615	$ 246,012		$ 136,501	$ (109,511)	$ 2,539,003	1
2	Rewired indicating circuits & installed new fire alarm system	2014	4,950		20	707	707	3,300	2
3	1st floor bathroom piping, tile drywall, outlets, paint, lights	2014	6,997		20	350	350	1,633	3
4	1st flooe countertops & shelving	2014	19,084		20	954	954	4,453	4
5	1st floor flooring	2014	11,689		20	584	584	2,727	5
6	Gasket - gear housing adaptor for generator	2016	2,887		20	82	82	233	6
7	Video monitoring system	2016	3,182		20	636	636	1,750	7
8	Window treatements 1st floor dining room	2016	2,548		20	510	510	1,402	8
9	Installed holding tank for boiler	2016	3,419		20	98	98	228	9
10	Dug up and replaced main walkway	2017	2,600		20	62	62	124	10
11	Generator repair	2018	3,964		39	85	85	85	11
12	Grease intercepter	2018	2,796		39	48	48	48	12
13	asphalt patching in parking lot	2018	4,500		15	50	50	50	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,946,231	$ 246,012		$ 140,667	$ (105,345)	$ 2,555,036	34

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,946,231	$ 246,012		$ 140,667	$ (105,345)	$ 2,555,036	1
2	Building Company								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	1st floor bathroom remodeling - tile, fixtures, counter tops	2015	27,461		20	1,373	1,373	5,492	9
10	1st floor carpeting	2015	11,689		20	584	584	2,337	10
11	1st floor corridor - wall coverings, ceiling tile, light fixtures	2015	76,719		20	3,836	3,836	19,004	11
12	Elevator door restrictor	2015	3,800		20	190	190	760	12
13	Ceiling lamps	2015	10,861		20	543	543	2,172	13
14	Wall guard protection	2015	6,920		20	346	346	1,384	14
15	Front entrance - windows, roof, sprinkler and gutters	2015	108,854		20	5,443	5,443	21,771	15
16	Installed wall coverings in offices	2015	19,776		20	989	989	3,956	16
17	Poured sidewalk	2015	7,052		20	353	353	1,411	17
18	Construction of seatwall and pillars with lights and patio	2015	27,135		20	1,357	1,357	5,428	18
19	Landscaping	2015	2,614		20	131	131	524	19
20	New heating unit and duct work	2015	7,384		20	369	369	1,476	20
21	Installed window treatements	2015	25,915		20	1,296	1,296	5,184	21
22	Custom nursing stations	2015	34,379		20	1,719	1,719	6,876	22
23	Wall covering in office and corridor and 30 corner guards	2015	29,306		20	1,465	1,465	5,861	23
24	Signage for corridor and receprion area	2015	9,825		20	491	491	1,964	24
25	Dining room light fixtures and flooring	2015	19,899		20	995	995	3,980	25
26	1st floor resident rooms and light fixtures	2015	4,916		20	246	246	984	26
27	Dining room corner guards	2015	2,967		20	148	148	593	27
28	Installed 6 windows	2015	6,000		20	300	300	1,200	28
29	69 aluminum siding insulated windows	2016	20,209		20	1,010	1,010	3,030	29
30	Kitchen cabinetry and 1st floor dining room	2016	3,288		20	164	164	492	30
31	11 drop sprinkler heads to new framework of ceiling	2016	6,470		20	324	324	972	31
32	Flooring for resident rooms	2016	5,960		20	298	298	894	32
33	New drywall for 1st floor dining room	2016	4,380		20	219	219	657	33
34	TOTAL (lines 1 thru 33)		$ 4,430,010	$ 246,012		$ 164,856	$ (81,156)	$ 2,653,438	34

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 4,430,010	$ 246,012		$ 164,856	$ (81,156)	$ 2,653,438	1
2	Installed Lighting Fixtures	2016	4,916		20	246	246	738	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,434,926	$ 246,012		$ 165,102	$ (80,910)	$ 2,654,176	34

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 4,434,926	$ 246,012		$ 165,102	$ (80,910)	$ 2,654,176	1
2									2
3									3
4	Related Party								4
5	Buildings:								5
6	Allocated from dynamic healthcare consulting	1993	48,444	1,242	39	1,384	142	35,064	6
7									7
8									8
9									9
10									10
11	Leasehold improvements:								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,483,370	$ 247,254		$ 166,486	$ (80,768)	$ 2,689,240	34

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 768,631	$	$ 76,863	$ 76,863	10	$ 600,357	71
72	Current Year Purchases	13,752		688	688	10	688	72
73	Fully Depreciated Assets	1,072,456		30	30	10	1,072,393	73
74	Related Party		813		(813)			74
75	TOTALS	$ 1,854,839	$ 813	$ 77,581	$ 76,768		$ 1,673,438	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	$	$	$		$ 44,500	76
77		Used Van	2005	16,080					16,080	77
78		Allocated from Dynamic Healthc	2017	31,583	366	1,360	994		27,099	78
79										79
80	TOTALS			$ 92,163	$ 366	$ 1,360	$ 994		$ 87,679	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)	$ 6,758,231	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 248,433	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 245,427	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,006)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,450,357	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 47,249 Description: Schedule Attached
(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	$	$ 15,732	17
18	Allocated Dynamic Hc Consultants			10,852	18
19					19
20					20
21	TOTAL		$	$ 26,584	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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-01	hrs	$ 193,583		$	$		$ 193,583	1
2	Licensed Speech and Language Development Therapist	39-01	hrs	93,328					93,328	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	199,307					199,307	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				173,819		173,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39.02					43,858		43,858	13
14	TOTAL			$ 486,218		$	$ 217,677		$ 703,895	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 NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 107,948	$ 359,864	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 516,796)	1,253,642	1,253,642	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,438	137,204	6
7	Other Prepaid Expenses	111,205	111,205	7
8	Accounts Receivable (owners or related parties)	656,458	656,458	8
9	Other(specify):		320,745	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,248,691	$ 2,839,118	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	1,554,372	1,933,834	15
16	Equipment, at Historical Cost	1,411,940	2,070,498	16
17	Accumulated Depreciation (book methods)	(2,627,448)	(4,678,896)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		132,269	22
23	Other(specify): Security Deposits	22,943	22,943	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 361,807	$ 2,353,240	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,610,498	$ 5,192,358	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 679,445	$ 679,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	645,151	826,023	29
30	Accrued Salaries Payable	365,140	365,140	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,863	19,863	31
32	Accrued Real Estate Taxes(Sch.IX-B)		46,299	32
33	Accrued Interest Payable	1,885	27,350	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,711,484	$ 1,964,120	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,461,512	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,461,512	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,711,484	$ 9,425,632	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 899,014	$ (4,233,274)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,610,498	$ 5,192,358	48

***(See instructions.)**

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,223,574	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,223,579	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(220,165)	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	(104,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (324,565)	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)**	$ 899,014	24 *

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 8,049,091	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,049,091	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,144	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 165,144	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	39,074	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,074	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,253,309	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,217,078	31
32	Health Care	2,674,398	32
33	General Administration	2,192,140	33
	B. Capital Expense		
34	Ownership	1,271,267	34
	C. Ancillary Expense		
35	Special Cost Centers	703,895	35
36	Provider Participation Fee	226,952	36
	D. Other Expenses (specify):		
37	PRIOR YEAR ADJ	187,744	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,473,474	40
41	**Income before Income Taxes (line 30 minus line 40)****	(220,165)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (220,165)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,824,201	44
45	Private Pay - Net Inpatient Revenue	1,975,943	45
46	Medicare - Net Inpatient Revenue	3,248,947	46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,049,091	49

**TAX RETURN PREPARED ON CASH BASIS

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.

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

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

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,032	2,160	$ 77,962	$ 36.09	1
2	Assistant Director of Nursing	2,308	2,588	88,444	34.17	2
3	Registered Nurses	13,296	14,135	481,838	34.09	3
4	Licensed Practical Nurses	15,936	17,280	497,505	28.79	4
5	CNAs & Orderlies	52,001	57,137	866,002	15.16	5
6	CNA Trainees					6
7	Licensed Therapist	10,642	11,405	486,218	42.63	7
8	Rehab/Therapy Aides	2,306	2,513	58,653	23.34	8
9	Activity Director	1,959	2,135	39,124	18.33	9
10	Activity Assistants	14,131	15,469	180,273	11.65	10
11	Social Service Workers	1,692	1,820	46,636	25.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,080	66,168	31.81	17
18	Housekeepers	15	15	189	12.60	18
19	Laundry					19
20	Administrator	1,728	1,760	91,657	52.08	20
21	Assistant Administrator	107	107	2,841	26.55	21
22	Other Administrative					22
23	Office Manager	794	1,052	21,040	20.00	23
24	Clerical	9,722	10,360	283,620	27.38	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					31
32	Other Health Care(specify)	2,977	3,171	98,660	31.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,598	145,187	$ 3,386,830 *	$ 23.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	24,759	10-3	38
39	Pharmacist Consultant	H	15,576	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,834	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	MDS CONSULTING		18,387		47
48					48
49	TOTAL (lines 35 - 48)		$ 74,556		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	15	$ 793	10-3	50
51	Licensed Practical Nurses	323	17,676	10-3	51
52	Certified Nurse Assistants/Aides	337	9,583	10-3	52
53	TOTAL (lines 50 - 52)	675	$ 28,052		53

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ann Marie Harrington	ADMINISTRATOR		$ 91,657
Kristen Stefaniak	ASST ADMIN		2,841
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,498

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
		$
SEE ATTACHED		137,206
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 137,206

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,542
Unemployment Compensation Insurance	29,422
FICA Taxes	252,928
Employee Health Insurance	143,053
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits Other	24,055
Dental	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,000

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	55,537
Health Care Worker Background Check	227
(Indicate # of checks performed 6)	
Patient Background Checks 238	2,378
TRUST/FRANCHISE/CONTRIB/ETC	10,290
MARKETING/ADV/PROMO	59,202
LICENSES/DUES/SUBSCRIPTIONS	21,992
MGMT CO ALLOC	2,189
TRUST/FRANCHISE/CONTRIB/ETC	(10,290)
Less: Public Relations Expense	(0)
Non-allowable advertising	(59,202)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Allocated from Dynamic Healthcare	542
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 542

* Attach copy of IMRF notifications

**See instructions.

WILLOW CREST NURSING PAVILION
LEGAL EXPENSES
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST	
02/22/18	VON BRIESEN & ROPER , S.C		LABOR & EMPLOYMENT	67.00	
09/24/18	VON BRIESEN & ROPER , S.C		LABOR & EMPLOYMENT	260.00	
11/20/18	VON BRIESEN & ROPER , S.C		LABOR & EMPLOYMENT	4,478.00	
12/17/18	VON BRIESEN & ROPER , S.C		LABOR & EMPLOYMENT	5,446.00	
01/22/19	VON BRIESEN & ROPER , S.C		LABOR & EMPLOYMENT	4,582.00	
03/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	840.00	
04/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	1,767.75	
05/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	558.84	
06/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	312.00	
06/25/18	MUCH SHELIST, P.C.		DOMESTIC CORPORATION ANNUAL REPORT	350.00	
07/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	422.82	
08/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	153.00	
08/29/18	MUCH SHELIST, P.C.		DOMESTIC CORPORATION ANNUAL REPORT	250.00	
09/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	3,065.50	
10/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	324.99	
11/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	988.26	
12/01/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	546.00	
01/01/19	MUCH SHELIST, P.C.		GENERAL COUNSELING	376.83	
11/30/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	457.00	
12/31/18	MUCH SHELIST, P.C.		GENERAL COUNSELING	2,068.33	
02/28/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	405.00	
03/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	411.00	
04/30/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	22.50	
05/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	517.50	
01/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	441.64	
07/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	99.90	
06/30/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	1,404.78	
08/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	109.68	
09/30/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	225.00	
11/01/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	461.04	
11/30/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	782.50	
12/31/18	STONE PORGRUND & KOREY LLC		GENERAL LITIGATION & COLLECTIONS	1,816.75	
03/26/18	SCOTT & KRAUS , LLC		LOAN MODIFICATION	930.50	

			TOTAL LEGAL FEES	34,942.11	
				==========	

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. **Healthcare Council of Illinois 19,581**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 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?
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **226,952**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

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