FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0020792

Facility Name: WILLOWS HEALTH CENTER

Address: 4054 ALBRIGHT LANE (Number) ROCKFORD (City) 61103 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-654-2530 **Fax #** 815-654-2545

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1972

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MARK TICKNOR **Telephone Number:** 815-316-1518
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 07/01/2017 to 06/30/2018 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) MARK TICKNOR
(Title) TREASURER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	36	Sheltered Care (SC)	36	13,140	5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,046	15,279	4,504	24,829	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		12,582		12,582	12
13	DD 16 OR LESS					13
14	TOTALS	5,046	27,861	4,504	37,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.71%

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)
outpatient therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 07/01/1972

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,835

Medicare Intermediary NHIC

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2018 Fiscal Year: 06/30/2018

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	818,280	119,868	36,060	974,208		974,208		974,208			1
2	Food Purchase		495,096		495,096		495,096		495,096			2
3	Housekeeping	149,484	19,860		169,344		169,344		169,344			3
4	Laundry	38,616	172,497		211,113		211,113		211,113			4
5	Heat and Other Utilities			199,725	199,725		199,725		199,725			5
6	Maintenance	194,808	112,526	207,078	514,412		514,412		514,412			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,201,188	919,847	442,863	2,563,898		2,563,898		2,563,898			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,262,783	527,400	1,448,075	5,238,258		5,238,258		5,238,258			10
10a	Therapy											10a
11	Activities											11
12	Social Services	240,535	12,190	14,806	267,531		267,531		267,531			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,503,318	539,590	1,462,881	5,505,789		5,505,789		5,505,789			16
	C. General Administration											
17	Administrative	4,200			4,200		4,200		4,200			17
18	Directors Fees											18
19	Professional Services			64,494	64,494		64,494		64,494			19
20	Dues, Fees, Subscriptions & Promotions			16,648	16,648		16,648		16,648			20
21	Clerical & General Office Expenses	629,733	13,927	19,159	662,819		662,819		662,819			21
22	Employee Benefits & Payroll Taxes			1,325,877	1,325,877		1,325,877		1,325,877			22
23	Inservice Training & Education			20,448	20,448		20,448		20,448			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			143,604	143,604		143,604		143,604			26
27	Other (specify):*											27
28	**TOTAL General Administration**	633,933	13,927	1,590,230	2,238,090		2,238,090		2,238,090			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,338,439	1,473,364	3,495,974	10,307,777		10,307,777		10,307,777			29

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

Facility Name & ID Number WILLOWS HEALTH CENTER #0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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			546,510	546,510		546,510		546,510			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			546,510	546,510		546,510		546,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			197,820	197,820		197,820		197,820			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,252	185,252		185,252		185,252			42
43	Other (specify):*	134,766		170,232	304,998		304,998		304,998			43
44	**TOTAL Special Cost Centers**	134,766		553,304	688,070		688,070		688,070			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,473,205	1,473,364	4,595,788	11,542,357		11,542,357		11,542,357			45

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	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			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		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

WILLOWS HEALTH CENTER

ID# 0020792

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 **Report Period Beginning:** 07/01/2017 **Ending:** 06/30/2018

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	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)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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
WILLOWS HEALTH CENTER	100			WESLEY WILLOWS	ROCKFORD	CCRC

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

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

1 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		MANAGEMENT FEE	$ 4,200	WESLEY WILLOWS	0.00%	$ 4,200	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 4,200			$ 4,200	$ *	14

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	Linda Chang	BOD						1
2	Joe Clinton	BOD						2
3	Mike Davis	BOD						3
4	Rebecca Epperson	BOD						4
5	Anne Hammes	BOD						5
6	Mark McClenathan	BOD						6
7	Denise Popp	BOD						7
8	Joe Scandroli	BOD						8
9	David Schmitt	BOD						9
10	John Schockey	BOD						10
11	Don Williams	BOD						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Linda Chang	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	$ 0		1
2	Joe Clinton	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		2
3	Mike Davis	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		3
4	Rebecca Epperson	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		4
5	Anne Hammes	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		5
6	Mark McClenathan	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		6
7	Denise Popp	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		7
8	Joe Scandroli	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		8
9	David Schmitt	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		9
10	John Schockey	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		10
11	Don Williams	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 6/30/2018

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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		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 WILLOWS HEALTH CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0020792

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.			$	$
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 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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	NURSING HOME	100,000	1974	$ 14,007	1
2	NURSING HOME	30,680	1994	7,729	2
3	TOTALS	130,680		$ 21,736	3

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	127		1974	1974	$ 1,138,143	$ 22,763	50	$ 22,763	$	$ 1,001,572	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1996	1,027,018	25,675	40	25,675		564,850	9
10	VARIOUS			1999	276,540		5-15			276,540	10
11	VARIOUS			2000	25,023		15			25,023	11
12	VARIOUS			2001	124,603		7-15			124,603	12
13	VARIOUS			2002	108,978		7-15			108,978	13
14	VARIOUS			2003	275,984		10-15			275,984	14
15	VARIOUS			2004	47,559		10-15			47,559	15
16	VARIOUS			2005	38,401	2,470	10-20	2,470		32,777	16
17	VARIOUS			2006	352,273	23,485	15	23,485		287,336	17
18	VARIOUS			2007	17,691	1,180	15	1,180		12,879	18
19	FLOORING			2008	15,514	1,034	15	1,034		10,463	19
20	DOOR CLOSERS			2008	46,479	3,099	15	3,099		31,544	20
21	MIXING VALVE			2008	4,700	313	15	313		3,203	21
22	LOCKER ROOM RENOVATIONS			2008	9,432	629	15	629		6,080	22
23	AIR DRYER			2008	3,780	252	15	252		2,450	23
24	ALARMING			2008	1,176	78	15	78		755	24
25	FLOORING			2009	24,320	1,621	15	1,621		14,749	25
26	ROOFING			2009	5,888	393	15	393		3,602	26
27	ALARMING			2009	3,024	202	15	202		1,839	27
28	ELEVATOR REBUILD			2009	12,689	846	15	846		7,755	28
29	GENERATOR UPGRADE			2009	13,139	876	15	876		7,689	29
30	CALL SYSTEM UPGRADE			2009	5,378	359	15	359		3,201	30
31	CHILLERS			2009	3,136	209	15	209		1,846	31
32	KITCHEN HOOD			2009	4,553	304	15	304		2,710	32
33	ENTRYWAY COLUMNS			2010	4,800	320	15	320		2,560	33
34	RADIO SYSTEM UPGRADE			2010	3,622	419	15	419		3,238	34
35	INTAKE AIR FAN			2010	2,267	151	15	151		1,246	35
36	FLOORING ROOM F15			2010	2,204	147	15	147		1,224	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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	FLOORING AND CEILING PANELS D109&F102	2010	$ 2,741	$ 183	15	$ 183	$	$ 1,403	37
38	UNDERCOUNTER FREEZER UNIT	2010	2,353	157	15	157		1,202	38
39	FLOORING F5&6, D114,118,120,123,126&127	2010	9,530	635	15	635		4,608	39
40	CHILLED WATER SYSTEM BOILER UPDATE	2011	5,369	358	15	358		2,596	40
41	FLOORING F3,106,108&120, D115&122	2011	6,190	413	15	413		2,779	41
42	CHILLER LANDSCAPING	2011	5,925	395	15	395		2,567	42
43	DOOR REPLACEMENTS, BREEZEWAY, PC ENTR, MAIN	2012	31,246	2,083	15	2,083		12,933	43
44	KEYS AND LOCK RESET	2012	582	39	15	39		247	44
45	FLOORING F1,15&101, D110	2012	5,345	356	15	356		2,174	45
46	WINDOW REPLACEMENT COMPLETE BUILDING	2012	207,920	13,861	15	13,861		84,384	46
47	YORK CONDENSING UNIT	2012	5,986	399	15	399		2,461	47
48	GAS FIRED BOILER AND HOT WATER PUMPS	2013	411,152	16,608	15-40	16,608		91,347	48
49	KITCHEN MAKEUP UNIT	2013	54,703	3,647	15	3,647		19,983	49
50	MEDICARE RM COMPLETE RENOVATION 15 RMS 20 BEDS	2013	346,397	34,639	10	34,639		168,578	50
51	D1-1&2,D2,D3-1&2,D4,D5-1&2,D6,D7-1&2,D8,D9-1&2,D10								51
52	D11,D12,D13,D14,D15 INCLUDING FLOORING, ELECTRICAL								52
53	LIGHTING, PLUMBING, DOORS FIXTURES AND PAINTING								53
54									54
55	HOT WATER SYSTEM UPGRADE	2013	40,314	4,031	10	4,031		19,147	55
56	FLOORING, ROOMS F-19,100,101,106,108,11,F15	2014	5,960	598	10	598		2,222	56
57	FLOORING, ROOMS F-107,D116,102,105,112,101,104,106,								57
58	F-116 AND F 7	2015	20,869	1,757	10	1,757		5,586	58
59	INSTALL POWER DOORS AND RENOVATE ENTRANCE	2015	19,329	1,933	10	1,933		5,960	59
60	REKEYING ALL INTERIOR AND EXTERIOR DOORS	2015	34,542	3,455	10	3,455		10,940	60
61									61
62	FLOORING ROOMS F110,F120,D113,D128,F9,F115,F3	2015	6,425	643	10	643		1,708	62
63	FLOORING ROOMS D107,F8,F19,F117,F4,F7,F111	2016	6,464	646	10	646		1,431	63
64	REROOF REHAB AREA	2016	178,404	17,840	10	17,840		39,397	64
65	ACCOUSTICAL CEILINGS ALL ROOMS	2016	14,265	1,427	10	1,427		3,082	65
66	WOOD FLOORING HC CORRIDORS	2016	100,515	838	10	838		2,514	66
67									67
68	SHOWER ROOM RETILING, ELECTRICAL & PLUMBING	2016	31,679	3,168	10	3,168		6,072	68
69	NEW CHILLERS AND CONTROLS	2017	1,677,780	41,945	30	41,945		41,945	69
70	TOTAL (lines 4 thru 69)		$ 6,830,299	$ 238,879		$ 238,879	$	$ 3,401,521	70

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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		$ 6,830,299	$ 238,879		$ 238,879	$	$ 3,401,521	1
2	Kirks Place Deck for residents adjacent to memory care unit	2017	42,422	1,944	20	1,944		1,944	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)		$ 6,872,721	$ 240,823		$ 240,823	$	$ 3,403,465	34

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 3,543,617	$ 267,017	$ 267,017	$		$ 2,088,266	71
72	Current Year Purchases	351,507	38,670	38,670			38,670	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,895,124	$ 305,687	$ 305,687	$		$ 2,126,936	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,789,581	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 546,510	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 546,510	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,530,401	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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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
   - ☐ NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER

STATE OF ILLINOIS
0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2018 (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	$ (3,267,054)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 792,000)	368,017		3
4	Supply Inventory (priced at cost)	6,938		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,892,099)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,736		13
14	Buildings, at Historical Cost	6,872,721		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,895,124		16
17	Accumulated Depreciation (book methods)	(5,530,401)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	13,188		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,272,368	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,380,269	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 793,980	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,239		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,095,219	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,095,219	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,285,050	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,380,269	$	48

*(See instructions.)

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,028,920	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,028,920	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(746,312)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,442	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (743,870)	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)**	$ 1,285,050	24 *

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 9,773,088	1
2	Discounts and Allowances for all Levels	(878,408)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,894,680	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	249,408	5
6	Therapy	1,021,318	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,270,726	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	600	15
16	Rental of Facility Space		16
17	Sale of Drugs	152,383	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	149,731	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 302,714	23
	D. Non-Operating Revenue		
24	Contributions	238,244	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 238,244	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Companion Services	89,681	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 89,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,796,045	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,563,898	31
32	Health Care	5,505,789	32
33	General Administration	2,238,090	33
	B. Capital Expense		
34	Ownership	546,510	34
	C. Ancillary Expense		
35	Special Cost Centers	197,820	35
36	Provider Participation Fee	185,252	36
	D. Other Expenses (specify):		
37	HR, Marketing, Fund Development	304,998	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,542,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	(746,312)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (746,312)	43

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

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

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

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

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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	2,000	2,080	$ 99,764	$ 47.96	1
2	Assistant Director of Nursing	12,000	12,480	402,127	32.22	2
3	Registered Nurses	13,829	14,382	518,745	36.07	3
4	Licensed Practical Nurses	22,115	23,000	826,246	35.92	4
5	CNAs & Orderlies	82,593	85,897	1,415,900	16.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,217	12,706	240,535	18.93	11
12	Dietician	2,000	2,080	43,403	20.87	12
13	Food Service Supervisor	6,600	6,864	99,466	14.49	13
14	Head Cook	4,000	4,160	81,984	19.71	14
15	Cook Helpers/Assistants	37,254	38,744	436,723	11.27	15
16	Dishwashers	14,875	15,470	156,705	10.13	16
17	Maintenance Workers	10,623	11,048	194,808	17.63	17
18	Housekeepers	13,586	14,129	149,484	10.58	18
19	Laundry	3,658	3,804	38,616	10.15	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	100	100	4,200	42.00	22
23	Office Manager					23
24	Clerical	14,932	15,529	629,733	40.55	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)					32
33	Other(specify) HR/Mktg/Fund	6,043	6,285	134,766	21.44	33
34	TOTAL (lines 1 - 33)	258,425	268,758	$ 5,473,205 *	$ 20.36	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,799	$ 331,938		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	19,157	478,784		52
53	TOTAL (lines 50 - 52)	26,956	$ 810,722		53

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wesley Willows	Mgmt Fee	0	$ 4,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 4,200

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
Paylocity	Payroll Processing	$ 24,027
Entre	IT Support	25,467
RSM	Audit	15,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 64,494

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 125,000
Unemployment Compensation Insurance	2,529
FICA Taxes	399,130
Employee Health Insurance	627,571
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403B Retirement Plan	91,772
Uniforms	8,283
Tuition Reimbursement	17,496
EE Fringe Benefits	54,096
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,325,877

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	
Health Care Worker Background Check	2,445
(Indicate # of checks performed 150)	
Patient Background Checks 100	
Help Wanted Fees	14,203
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,648

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

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. **Leading Age Illinois**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,874** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **49,823**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM**

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

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