		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0036533

Facility Name: WILLOW CREST NRSING PAVILION

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

County: DEKALB

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

HFS ID Number:

Date of Initial License for Current Owners: 1/11/1991

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 1/1/2020 to 12/31/2020 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, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,594	7,377	5,154	31,125	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,594	7,377	5,154	31,125	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.31%

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 [X] 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 5,154

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	308,626	17,378	21,058	347,062		347,062		347,062			1
2	Food Purchase		186,703		186,703	(12,122)	174,581	(3,178)	171,403			2
3	Housekeeping	141,326	26,589		167,915		167,915		167,915			3
4	Laundry	72,925	24,126	3,092	100,143		100,143		100,143			4
5	Heat and Other Utilities			117,702	117,702		117,702	1,126	118,828			5
6	Maintenance	102,789	90,938	30,748	224,475		224,475	16,453	240,928			6
7	Other (specify):*			13,163	13,163		13,163		13,163			7
8	TOTAL General Services	625,666	345,734	185,763	1,157,163	(12,122)	1,145,041	14,401	1,159,442			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,631,054	289,932	273,873	3,194,859		3,194,859	12,204	3,207,063			10
10a	Therapy	512,264	1,039		513,303		513,303		513,303			10a
11	Activities	211,933	10,997	1,150	224,080		224,080		224,080			11
12	Social Services	46,247		2,948	49,195		49,195		49,195			12
13	CNA Training											13
14	Program Transportation			754	754		754		754			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,401,498	301,968	290,725	3,994,191		3,994,191	12,204	4,006,395			16
	C. General Administration											
17	Administrative	121,922			121,922		121,922	244,666	366,588			17
18	Directors Fees											18
19	Professional Services			215,230	215,230		215,230	14,697	229,927			19
20	Dues, Fees, Subscriptions & Promotions			130,507	130,507		130,507	(78,174)	52,333			20
21	Clerical & General Office Expenses	128,025	16,269	366,942	511,236		511,236	(192,911)	318,325			21
22	Employee Benefits & Payroll Taxes			777,104	777,104	12,122	789,226		789,226			22
23	Inservice Training & Education			4,829	4,829		4,829		4,829			23
24	Travel and Seminar			7,877	7,877		7,877	265	8,142			24
25	Other Admin. Staff Transportation							2,633	2,633			25
26	Insurance-Prop.Liab.Malpractice			357,869	357,869		357,869	10,818	368,687			26
27	Other (specify):*	81,264		162,356	243,620		243,620	(99,742)	143,878			27
28	TOTAL General Administration	331,211	16,269	2,022,714	2,370,194	12,122	2,382,316	(97,748)	2,284,568			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,358,375	663,971	2,499,202	7,521,548		7,521,548	(71,143)	7,450,405			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 NRSING PAVILION **#0036533 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,058	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		0	
				21,058
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,092	
	CONTRACTED LAUNDRY SERVICES		0	
				3,092
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		13,324	
	ELECTRICITY		73,532	
	WATER		21,802	
	CABLE TV - LOBBY		9,044	
				117,702
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,220	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,127	
	ELEVATOR MAINTENANCE & REPAIR		9,401	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		0	
				30,748
7	**OTHER**			
	SCAVENGER		13,163	
	SECURITY SERVICE		0	
				13,163
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	195,001	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	72,216	
	PHARMACY CONSULTANT	XVIII B 39-2	6,656	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2		
				273,873
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,150	
				1,150
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,948	
				2,948
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		754	
				754
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	87,817	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	127,413	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				215,230
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	63,447	
	EMPLOYEE WANT ADS	XIX F	18,214	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8,045	
	LICENSES & PERMITS	XIX F	18,709	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	16,751	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	576	
	PATIENT BACKGROUND CHECKS	XIX F	4,765	
				130,507
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,944	
	EQUIPMENT REPAIR & MAINTENANCE		23,405	
	OUTSIDE CLERICAL SERVICES		303,087	
	PENALTIES / OVERDRAFT CHARGES	VI 18	17,497	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,009	
	MESSENGER SERVICE		0	
				366,942

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	326,535	
	UNEMPLOYMENT COMPENSATION	XIX D	29,156	
	WORKERS COMPENSATION INSURANCE	XIX D	116,791	
	HOSPITALIZATION INSURANCE	XIX D	222,130	
	EMPLOYEE BENEFITS - OTHER	XIX D	82,492	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				777,104
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		4,829	
				4,829
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	7,877	
				7,877
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		357,869	
				357,869
27	**OTHER**			
	BAD DEBTS	VI 24	162,356	
				162,356

GRAND TOTAL COLUMN 3 OTHER **2,499,202**

WILLOW CREST NRSING PAVILION
SCHEDULES
12/31/2020

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

TOTAL FOOD PURCHASE	186,703
LESS SALES TAX	(3,178)
NET FOOD	183,525
TOTAL PATIENT CENSUS	31,125
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	93,375
ADD # EMPLOYEE MEALS/DAY	18
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	6,588
PATIENT MEALS	93,375
ADD EMPLOYEE MEALS	6,588
TOTAL MEALS/YEAR	99,963
NET FOOD	183,525
DIVIDE TOTAL MEALS/YEAR	99,963
COST PER MEAL	1.84
TIMES EMPLOYEE MEALS	6,588
EMPLOYEE MEAL RECLASSIFICATION	**12,122**

Facility Name & ID Number WILLOW CREST NRSING PAVILION #0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			46,020	46,020		46,020	165,415	211,435			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,636	44,636		44,636	272,697	317,333			32
33	Real Estate Taxes							54,887	54,887			33
34	Rent-Facility & Grounds			1,074,000	1,074,000		1,074,000	(1,074,000)				34
35	Rent-Equipment & Vehicles			39,392	39,392		39,392	10,122	49,514			35
36	Other (specify):*							47,841	47,841			36
37	**TOTAL Ownership**			1,204,048	1,204,048		1,204,048	(523,038)	681,010			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,955		39,955		39,955		39,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,876	218,876		218,876		218,876			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		39,955	218,876	258,831		258,831		258,831			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,358,375	703,926	3,922,126	8,984,427		8,984,427	(594,181)	8,390,246			45

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	57,075	30		9
10	Interest and Other Investment Income	(29,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,178)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(17,497)	21		18
19	Entertainment		20		19
20	Contributions	(16,751)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,356)	27		24
25	Fund Raising, Advertising and Promotional	(63,447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (235,386)		$	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)	(358,795)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (358,795)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (594,181)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WILLOW CREST NRSING PAVILION

ID# 0036533

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	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 WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,178)	0	0	0	0	0	0	0	0	0	0	(3,178)	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	1,126	0	0	0	0	0	0	0	0	1,126	5
6	Maintenance	0	0	7,000	9,453	0	0	0	0	0	0	0	16,453	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,178)	0	8,126	9,453	0	0	0	0	0	0	0	14,401	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	12,204	0	0	0	0	0	0	0	0	12,204	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	12,204	0	0	0	0	0	0	0	0	12,204	16
	C. General Administration													
17	Administrative	0	0	0	244,666	0	0	0	0	0	0	0	244,666	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,377	3,320	0	0	0	0	0	0	0	0	14,697	19
20	Fees, Subscriptions & Promotions	(80,198)	0	2,024	0	0	0	0	0	0	0	0	(78,174)	20
21	Clerical & General Office Expenses	(17,497)	0	(194,438)	19,024	0	0	0	0	0	0	0	(192,911)	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	265	0	0	0	0	0	0	0	0	265	24
25	Other Admin. Staff Transportation	0	0	2,633	0	0	0	0	0	0	0	0	2,633	25
26	Insurance-Prop.Liab.Malpractice	0	7,529	3,289	0	0	0	0	0	0	0	0	10,818	26
27	Other (specify):*	(162,356)	0	62,614	0	0	0	0	0	0	0	0	(99,742)	27
28	**TOTAL General Administration**	(260,051)	18,906	(120,293)	263,690	0	0	0	0	0	0	0	(97,748)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(263,229)	18,906	(99,963)	273,143	0	0	0	0	0	0	0	(71,143)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	57,075	107,144	1,196	0	0	0	0	0	0	0	0	165,415	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,232)	299,713	2,216	0	0	0	0	0	0	0	0	272,697	32
33	Real Estate Taxes	0	50,722	4,165	0	0	0	0	0	0	0	0	54,887	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	10,122	0	0	0	0	0	0	0	0	10,122	35
36	Other (specify):*	0	47,841	0	0	0	0	0	0	0	0	0	47,841	36
37	**TOTAL Ownership**	27,843	(568,580)	17,699	0	0	0	0	0	0	0	0	(523,038)	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)**	(235,386)	(549,674)	(82,264)	273,143	0	0	0	0	0	0	0	(594,181)	45

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	RENT	$ 1,074,000	WILLOW CREST BUIDING LLC	100.00%	$	$ (1,074,000)	1
2	V								2
3	V	32	INTEREST				294,475	294,475	3
4	V	19	PROFESSIONAL FEES				11,377	11,377	4
5	V	33	REAL ESTATE TAX				50,722	50,722	5
6	V	26	INSURANCE				7,529	7,529	6
7	V	36	MIP INSURANCE				47,841	47,841	7
8	V	30	DEPRECIATION				107,144	107,144	8
9	V	32	AMORTIZATION				5,238	5,238	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,000			$ 524,326	$ * (549,674)	14

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	BOOKKEEPING SERVICES	$ 303,087	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (303,087)	15
16	V								16
17	V								17
18	V								18
19	V	5	UTILITIES				1,126	1,126	19
20	V	6	REPAIR & MAINT.-OTHER EXPENSE				7,000	7,000	20
21	V	10	NURSE CONSULTANT				12,204	12,204	21
22	V	19	PROFESSIONAL FEES				3,320	3,320	22
23	V	20	DUES AND SUBSCRIPTION				2,024	2,024	23
24	V	21	CLERICAL & GENERAL - SALARIES				83,215	83,215	24
25	V	21	CLERICAL & GENERAL-OTHER EXPENSE				25,434	25,434	25
26	V	24	SEMINARS AND TRAVEL				265	265	26
27	V	25	AUTO EXPENSE				2,633	2,633	27
28	V	26	INSURANCE				3,289	3,289	28
29	V	27	EMP. BEN. - GEN, ADMIN.				62,614	62,614	29
30	V	30	DEPRECIATION				1,196	1,196	30
31	V	32	INTEREST				2,216	2,216	31
32	V	33	REAL ESTATE TAXES				4,165	4,165	32
33	V	35	AUTO RENTAL				9,848	9,848	33
34	V	35	EQUIPMENT RENTAL				274	274	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 303,087			$ 220,823	$ * (82,264)	39

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 9,453	$ 9,453	15
16	V	17	ADMIN COMP - M MAUER				31,563	31,563	16
17	V	17	ADMIN COMP - M AARON				40,125	40,125	17
18	V	17	ADMIN COMP - F AARON				41,537	41,537	18
19	V	17	ADMIN COMP - D AARON				3,231	3,231	19
20	V	17	ADMIN COMP - S GOLDSTEIN				57,500	57,500	20
21	V	17	ADMIN COMP - R AARON				7,180	7,180	21
22	V	17	ADMIN COMP - S HARAMARAS						22
23	V	17	ADMIN COMP - D KUFTA				26,968	26,968	23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS				21,881	21,881	25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				14,681	14,681	26
27	V	21	CLERICAL COMP - S AARON				12,248	12,248	27
28	V	21	CLERICAL COMP - E MARYLES				6,776	6,776	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 273,143	$ * 273,143	39

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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				4
5	Marshall Mauer	10.78%	Waterfront Terrace Inc	Chicago				5
6	Sharon Aaron	0.56%	Woodbridge Nursing Pavilion Ltd	Chicago				6
7	Chani Mauer	6.05%						7
8	Dennis Nehmer	0.56%						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 NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	10.78	SEE ATTACHED	5.05	12.63	SALARY	$ 31,563	17-07	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIV	23.79		6.42	12.84	SALARY	40,125	17-07	2
3	DANIEL AARON	RELATIVE	ADMINISTRATIVE			0.75	1.36	SALARY	3,231	17-07	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIV	13.10		14.66		SALARY	42,000	17-01	4
5	ROBERT AARON	RELATIVE	ADMINISTRATIVE			2		SALARY	7,180	17-07	5
6	SHARON AARON	SHAREHOLDER	CLERICAL	0.56		5.11	12.78	SALARY	12,248	21-01	6
7	DENNIS NEHMER	SHAREHOLDER	ADMINISTRATIV	0.56		6.45	16.13	SALARY	9,453	06-01	7
8	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.56		6.42	16.05	SALARY	26,968	17-07	8
9	FRED AARON	SHAREHOLDER	ADMINISTRATIV	13.10		14.66		SALARY	41,537	17-07	9
10	STEVEN GOLDSTEIN	RELATIVE	ADMINISTRATIVE			10		SALARY	57,500	17-07	10
11	ESTHER MARYLES	SHAREHOLDER	CLERICAL	6.05		3.76	9.40	SALARY	6,776	21-07	11
12											12
13								TOTAL	$ 278,581		13

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

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	296,074	9	$ 10,707	$	31,125	$ 1,126	1
2	6	REPAIR & MAINT.-OTHER EXPEI	PATIENT DAYS	296,074	9	66,584		31,125	7,000	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092		31,125	12,204	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579		31,125	3,320	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254		31,125	2,024	5
6	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	296,074	9	791,573	791,573	31,125	83,215	6
7	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	296,074	9	241,939		31,125	25,434	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520		31,125	265	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044		31,125	2,633	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289		31,125	3,289	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611		31,125	62,614	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374		31,125	1,196	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081		31,125	2,216	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621		31,125	4,165	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680		31,125	9,848	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605		31,125	274	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,100,553	$ 791,573		$ 220,823	25

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	5	$ 58,624	$ 58,624	6	$ 9,453	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	5	31,563	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000	6	40,125	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500	15	41,537	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	3,231	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000	10	57,500	6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541	2	7,180	7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022	6	26,968	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	5	132,015	132,015	7	21,881	11
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	5	14,681	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	5	12,248	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	4	6,776	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,623,121	$ 1,623,121		$ 273,143	25

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	WILLOW CREST BUIDING LLC						$	$			$	1
2	MIDLAND STATES BANK		X	MORTGAGE	$40,014.56	03/06/14	8,381,500	7,276,430	04/01/44	4.0000	294,475	2
3				LOAN COSTS	W/O OVER LOAN		157,151	121,792			5,238	3
4												4
5												5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL						PRIME+	1,436	6
7	RELATED PARTY	X		WORKING CAPITAL							43,200	7
8	MGMT ALLOCATION										2,216	8
9	TOTAL Facility Related				$40,014.56		$ 8,538,651	$ 7,398,222			$ 346,565	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,538,651	$ 7,398,222			$ 346,565	15

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

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

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	48,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	52,887	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,887	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	50,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,887	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	42,049	8
2016	45,325	9
2017	45,398	10
2018	47,060	11
2019	52,887	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW CREST NRSING PAVILION COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	NURSING HOME	$ 48,722.30	$ 48,722.30
2.			$	$
3.			$	$
4.	10-23-404-059-0000	DYNAMIC HEALTHCARE	$ 36,915.77	$ 4,165.00
5.		ALLOCATION	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,638.07	$ 52,887.30

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 X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 65,249	39	$ 65,249	$	$ 1,435,217	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				48,444			1,384	1,384		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			31,645	16
17	Various			1999	137,772		20			137,772	17
18	Various			2000	149,982		20	7,499	7,499	154,111	18
19	Various			2001	127,742		20	6,387	6,387	124,057	19
20	Various			2002	52,106		20	159	159	51,882	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)	36,779	25
26	Various			2008	74,672		20		(3,106)	74,672	26
27	Various			2009	29,315		20	387	387	18,486	27
28	Various			2010	48,685		20	2,027	2,027	21,185	28
29	Various			2011	36,459		20	2,918	2,918	27,990	29
30	Various			2012	137,257		20		(2,146)	137,257	30
31	Various			2013	147,694		20	15,355	15,355	163,049	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Financial Statement Depreciation			89,111			(89,111)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,926,059	$ 154,360		$ 101,365	$ (60,024)	$ 2,736,876	70

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		$ 3,926,059	$ 154,360		$ 101,365	$ (52,995)	$ 2,736,876	1
2	Rewired indicating circuits & installed new fire alarm system	2014	4,950		20	707	707	4,714	2
3	1st floor bathroom piping, tile drywall, outlets, paint, lights	2014	6,997		20	350	350	2,333	3
4	1st flooe countertops & shelving	2014	19,084		20	954	954	6,361	4
5	1st floor flooring	2014	11,689		20	584	584	3,895	5
6	Gasket - gear housing adaptor for generator	2016	2,887		20	82	82	397	6
7	Video monitoring system	2016	3,182		20	636	636	3,022	7
8	Window treatements _ 1st floor dining room	2016	2,548		20	510	510	2,422	8
9	Installed holding tank for boiler	2016	3,419		20	98	98	424	9
10	Dug up and replaced main walkway	2017	2,600		20	62	62	248	10
11	Generator repair	2018	3,964		39	85	85	255	11
12	Grease intercepter	2018	2,796		39	48	48	144	12
13	asphalt patching in parking lot	2018	4,500		15	50	50	150	13
14	service repair on hot water supply lines	2019	6,500		39	42	42	84	14
15	Hydronic Boiler	2020	3,098		39	73	73	73	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)		$ 4,004,273	$ 154,360		$ 105,646	$ (48,714)	$ 2,761,398	34

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,004,273	$ 154,360		$ 105,646	$ (48,714)	$ 2,761,398	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	8,238	9
10	1st floor carpeting	2015	11,689		20	584	584	3,505	10
11	1st floor corridor - wall coverings, ceiling tile, light fixtures	2015	76,719		20	3,836	3,836	26,676	11
12	Elevator door restrictor	2015	3,800		20	190	190	1,140	12
13	Ceiling lamps	2015	10,861		20	543	543	3,258	13
14	Wall guard protection	2015	6,920		20	346	346	2,076	14
15	Front entrance - windows, roof, sprinkler and gutters	2015	108,854		20	5,443	5,443	32,657	15
16	Installed wall coverings in offices	2015	19,776		20	989	989	5,934	16
17	Poured sidewalk	2015	7,052		20	353	353	2,117	17
18	Construction of seatwall and pillars with lights and patio	2015	27,135		20	1,357	1,357	8,142	18
19	Landscaping	2015	2,614		20	131	131	786	19
20	New heating unit and duct work	2015	7,384		20	369	369	2,214	20
21	Installed window treatements	2015	25,915		20	1,296	1,296	7,776	21
22	Custom nursing stations	2015	34,379		20	1,719	1,719	10,314	22
23	Wall covering in office and corridor and 30 corner guards	2015	29,306		20	1,465	1,465	8,791	23
24	Signage for corridor and receprion area	2015	9,825		20	491	491	2,946	24
25	Dining room light fixtures and flooring	2015	19,899		20	995	995	5,970	25
26	1st floor resident rooms and light fixtures	2015	4,916		20	246	246	1,476	26
27	Dining room corner guards	2015	2,967		20	148	148	889	27
28	Installed 6 windows	2015	6,000		20	300	300	1,800	28
29	69 aluminum siding insulated windows	2016	20,209		20	1,010	1,010	5,050	29
30	Kitchen cabinetry and 1st floor dining room	2016	3,288		20	164	164	820	30
31	11 drop sprinkler heads to new framework of ceiling	2016	6,470		20	324	324	1,620	31
32	Flooring for resident rooms	2016	5,960		20	298	298	1,490	32
33	New drywall for 1st floor dining room	2016	4,380		20	219	219	1,095	33
34	TOTAL (lines 1 thru 33)		$ 4,488,052	$ 154,360		$ 129,835	$ (24,525)	$ 2,908,178	34

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		$ 4,488,052	$ 154,360		$ 129,835	$ (24,525)	$ 2,908,178	1
2	Installed Lighting Fixtures	2016	4,916		20	246	246	1,230	2
3	Resident Rooms-Four Air Condition Units	2020	5,973		20	299	299	299	3
4	Recessed Troffer, Light Technology Fluorescent, Fixtures	2020	2,176		20	109	109	109	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)		$ 4,501,117	$ 154,360		$ 130,489	$ (23,871)	$ 2,909,816	34

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 804,601	$	$ 80,461	$ 80,461	10	$ 760,793	71
72	Current Year Purchases	2,670		133	133	10	133	72
73	Fully Depreciated Assets							73
74	RELATED PARTY			352	352			74
75	TOTALS	$ 807,271	$	$ 80,946	$ 80,946		$ 760,926	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										78
79										79
80	TOTALS			$ 60,580	$	$	$		$ 60,580	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)	$ 5,696,827	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,360	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 211,435	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 57,075	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,731,322	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 NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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.		$
13.		$
14.		$

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: $ 23,607 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	$ 733.00	$ 7,176	17
18	FACILITY	2019 FORD E350 BUS	948.00	8,609	18
19					19
20					20
21	TOTAL		$ #######	$ 15,785	21

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

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				68,911		68,911	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): RENTALS	39-2					(28,956)		0 (28,956)	13
14	TOTAL			$		$	$ 39,955		$ 39,955	14

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 953,786	$ 1,195,358	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 595,847)	1,621,024	1,621,024	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,946	122,493	6
7	Other Prepaid Expenses	389,560	389,560	7
8	Accounts Receivable (owners or related parties)	14,461	14,461	8
9	Other(specify): ESCROWS		455,681	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,083,777	$ 3,798,577	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	1,563,970	1,951,581	15
16	Equipment, at Historical Cost	1,439,888	2,102,956	16
17	Accumulated Depreciation (book methods)	(2,727,688)	(5,643,003)	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):			22
23	Other(specify): LOAN COSTS		121,792	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 276,170	$ 1,405,918	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,359,947	$ 5,204,495	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,455,443	$ 1,458,477	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	769,671	962,294	29
30	Accrued Salaries Payable	392,288	392,288	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,847	15,847	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,000	32
33	Accrued Interest Payable		24,254	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)**	$ 2,633,249	$ 2,903,160	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,083,807	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)**	$	$ 7,083,807	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,633,249	$ 9,986,967	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 726,698	$ (4,782,472)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,359,947	$ 5,204,495	48

***(See instructions.)**

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 373,421	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 373,421	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	353,277	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	( )	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)**	$ 353,277	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)**	$ 726,698	24 *

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

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 8,525,521	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,525,521	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	105,593	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 105,593	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***	29,232	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,232	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	823,289	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 823,289	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,483,635	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,157,163	31
32	Health Care	3,994,191	32
33	General Administration	2,370,194	33
	B. Capital Expense		
34	Ownership	1,204,048	34
	C. Ancillary Expense		
35	Special Cost Centers	39,955	35
36	Provider Participation Fee	218,876	36
	D. Other Expenses (specify):		
37	PRIOR YEAR ADJ	145,931	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,130,358	40
41	**Income before Income Taxes (line 30 minus line 40)****	353,277	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 353,277	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,561,609	44
45	Private Pay - Net Inpatient Revenue	1,361,726	45
46	Medicare - Net Inpatient Revenue	3,619,412	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,542,747	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 NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	2,040	2,080	$ 91,712	$ 44.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,642	14,634	554,945	37.92	3
4	Licensed Practical Nurses	20,570	22,771	728,970	32.01	4
5	CNAs & Orderlies	57,723	63,376	1,161,550	18.33	5
6	CNA Trainees					6
7	Licensed Therapist	9,007	9,908	434,807	43.88	7
8	Rehab/Therapy Aides	2,794	3,165	77,457	24.47	8
9	Activity Director	1,797	2,028	42,629	21.02	9
10	Activity Assistants	9,610	10,850	169,304	15.60	10
11	Social Service Workers	1,596	1,844	46,247	25.08	11
12	Dietician					12
13	Food Service Supervisor	3,956	4,219	89,672	21.25	13
14	Head Cook	7,305	7,760	123,949	15.97	14
15	Cook Helpers/Assistants	5,919	6,215	95,005	15.29	15
16	Dishwashers					16
17	Maintenance Workers	3,968	4,160	102,789	24.71	17
18	Housekeepers	8,417	9,152	141,326	15.44	18
19	Laundry	4,449	4,766	72,925	15.30	19
20	Administrator	2,040	2,080	94,265	45.32	20
21	Assistant Administrator	1,498	1,618	27,657	17.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,849	5,361	128,025	23.88	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 C: Care Plan Coord	1,976	2,231	93,877	42.08	32
33	Other(specify) ADMITTING	2,162	2,194	81,264	37.04	33
34	TOTAL (lines 1 - 33)	165,318	180,412	$ 4,358,375 *	$ 24.16	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	$ 21,058	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	72,216	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,656	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	1,150	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 113,080		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides	7,500	195,001	10-3	52
53	TOTAL (lines 50 - 52)	7,500	$ 195,001		53

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ZACH RUDDLE	ADMINISTRATOR	0	$ 94,265
LAURIE EBERLY	ASST. ADMIN	0	27,657
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,922

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 SCHEDULE ATTACHED		215,230
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 215,230

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,791
Unemployment Compensation Insurance	29,156
FICA Taxes	326,535
Employee Health Insurance	222,130
Employee Meals	12,122
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	82,492
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 789,226

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	$ 1,990
Advertising: Employee Recruitment	18,214
Health Care Worker Background Check	576
(Indicate # of checks performed 16)	
Patient Background Checks 476	4,765
TRUST/FRANCHISE/CONTRIB/ETC	16,751
MARKETING/ADV/PROMO	63,447
LICENSES/DUES/SUBSCRIPTIONS	24,764
MGMT CO ALLOC	2,024
TRUST/FRANCHISE/CONTRIB/ETC	(16,751)
Less: Public Relations Expense	(0)
Non-allowable advertising	(63,447)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,333

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,877
MGMT CO ALLOC	265
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,142

* Attach copy of IMRF notifications

**See instructions.

WILLOW CREST NRSING PAVILION
SCHEDULE - LEGAL
12/31/2020

DATE	FIRM NAME	DESCRIPTION	AMOUNT
1/1/2020	MUCH SHELIST	General Counseling	1,170.00
2/1/2020	MUCH SHELIST	General Counseling	164.00
3/1/2020	MUCH SHELIST	General Counseling	82.00
4/1/2020	MUCH SHELIST	General Counseling	507.40
7/29/2020	MUCH SHELIST	Annual Report	300.00
10/1/2020	MUCH SHELIST	General Counseling	820.00
12/1/2020	MUCH SHELIST	General Counseling	82.00
1/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,867.50
3/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	858.55
2/29/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,648.17
4/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,869.83
5/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	886.68
6/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,075.01
7/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	475.00
8/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	790.00
9/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,351.14
11/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	630.00
2/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	895.00
4/21/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,189.00
4/21/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	98.00
5/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	3,806.00
5/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,198.60
6/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	3,512.00
7/15/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	550.00
8/21/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	7,787.00
8/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	4,369.00
9/1/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	133.00
9/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	2,786.00
7/15/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	4,912.00
11/23/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	365.63
11/23/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	2,005.00
12/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	4,523.63
	TOTAL		**52,707.14**

Facility Name & ID Number WILLOW CREST NRSING PAVILION # 0036533 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC-$ 6,021

(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. $ 43,566 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?
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. $ 218,876
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. $ 12,122 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 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.