



Facility Name & ID Number The Willow of Anna, Inc.

# 0040881 Report Period Beginning: 01/01/00 Ending: 12/31/00

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,620	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	18,640	4,750		23,390	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,640	4,750		23,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.30%

D. How many bed-hold days during this year were paid by Public Aid? 54 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/01/95 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number The Willow of Anna, Inc. # 0040881 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	78,356	3,525	4,487	86,368		86,368		86,368		1
2	Food Purchase		96,395		96,395	(3,650)	92,745	(200)	92,545		2
3	Housekeeping	74,785	14,635		89,420		89,420		89,420		3
4	Laundry	33,760	8,799		42,559		42,559		42,559		4
5	Heat and Other Utilities			55,747	55,747		55,747	547	56,294		5
6	Maintenance	15,757		18,072	33,829		33,829	868	34,697		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	202,658	123,354	78,306	404,318	(3,650)	400,668	1,215	401,883		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,500	1,500		1,500		1,500		9
10	Nursing and Medical Records	418,433	18,197	3,318	439,948		439,948		439,948		10
10a	Therapy										10a
11	Activities	18,141	1,315		19,456		19,456		19,456		11
12	Social Services	13,760		1,509	15,269		15,269		15,269		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	450,334	19,512	6,327	476,173		476,173		476,173		16
	<b>C. General Administration</b>										
17	Administrative	55,546			55,546		55,546	16,864	72,410		17
18	Directors Fees										18
19	Professional Services			117,432	117,432		117,432	(105,030)	12,402		19
20	Dues, Fees, Subscriptions & Promotions			9,485	9,485	3,126	12,611	(5,470)	7,141		20
21	Clerical & General Office Expenses	31,353	20,311	13,502	65,166		65,166	26,644	91,810		21
22	Employee Benefits & Payroll Taxes			108,701	108,701	524	109,225	6,128	115,353		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,658	2,658		2,658		2,658		24
25	Other Admin. Staff Transportation			2,767	2,767		2,767	3,036	5,803		25
26	Insurance-Prop.Liab.Malpractice			27,661	27,661		27,661	917	28,578		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	86,899	20,311	282,206	389,416	3,650	393,066	(56,911)	336,155		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	739,891	163,177	366,839	1,269,907		1,269,907	(55,696)	1,214,211		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      The Willow of Anna, Inc.      #0040881      Report Period Beginning:      01/01/00      Ending:      12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			543	543	543	62,692	63,235				30
31	Amortization of Pre-Op. & Org.			438	438	438	6,481	6,919				31
32	Interest						188,525	188,525				32
33	Real Estate Taxes						22,864	22,864				33
34	Rent-Facility & Grounds			278,000	278,000	278,000	(274,418)	3,582				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			278,981	278,981	278,981	6,144	285,125				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,430	38,430	38,430		38,430				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			38,430	38,430	38,430		38,430				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	739,891	163,177	684,250	1,587,318	1,587,318	(49,552)	1,537,766				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 The Willow of Anna, Inc.

# 0040881

Report Period Beginning: 01/01/00

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**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	2,896	30		9
10	Interest and Other Investment Income	(2,553)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	2		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	(5,470)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>ABS Management</u>	(106,189)	19		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (111,516)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,739		34
35	Other- Attach Schedule <u>Allocate Indirect Costs</u>	59,225		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 61,964		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (49,552)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

The Willow of Anna, Inc. ID# 0040881  
 Report Period Beginning: 01/01/00  
 Ending: 12/31/00

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
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31			31
32			32
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40			40
41			41
42			42
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47			47
48			48
49			49
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67			67
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71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total		0	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Willow of Anna, Inc.

# 0040881 Report Period Beginning:

01/01/00

Ending:

12/31/00

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(200)	0	0	0	0	0	0	0	0	0	0	(200)	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	<b>TOTAL General Services</b>	<b>(200)</b>	<b>0</b>	<b>(200)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(5,470)	0	0	0	0	0	0	0	0	0	0	(5,470)	20
21	Clerical & General Office Expenses	0	520	0	0	0	0	0	0	0	0	0	520	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	<b>TOTAL General Administration</b>	<b>(5,470)</b>	<b>520</b>	<b>0</b>	<b>(4,950)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(5,670)</b>	<b>520</b>	<b>0</b>	<b>(5,150)</b>	<b>29</b>								



Facility Name & ID Number The Willow of Anna, Inc. # 0040881 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<a href="#">See Attached Schedule</a>		<a href="#">See Attached Schedule</a>		<a href="#">Anna, LLC.</a>	<a href="#">Anna</a>	<a href="#">Bldg. Rental</a>
				<a href="#">ABS Management</a>	<a href="#">Chicago</a>	<a href="#">Management</a>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<a href="#">34 Rent</a>	\$ <a href="#">278,000</a>	<a href="#">The Willow of Anna, LLC.</a>	<a href="#">100.00%</a>	\$	\$ <a href="#">(278,000)</a>	<a href="#">1</a>
2	V	<a href="#">33 Real Estate Tax</a>		<a href="#">The Willow of Anna, LLC.</a>		<a href="#">22,864</a>	<a href="#">22,864</a>	<a href="#">2</a>
3	V	<a href="#">30 Depreciation</a>		<a href="#">The Willow of Anna, LLC.</a>		<a href="#">59,796</a>	<a href="#">59,796</a>	<a href="#">3</a>
4	V	<a href="#">31 Amortization</a>		<a href="#">The Willow of Anna, LLC.</a>		<a href="#">6,481</a>	<a href="#">6,481</a>	<a href="#">4</a>
5	V	<a href="#">32 Interest</a>		<a href="#">The Willow of Anna, LLC.</a>		<a href="#">191,078</a>	<a href="#">191,078</a>	<a href="#">5</a>
6	V	<a href="#">21 Office</a>		<a href="#">The Willow of Anna, LLC.</a>		<a href="#">520</a>	<a href="#">520</a>	<a href="#">6</a>
7	V							<a href="#">7</a>
8	V							<a href="#">8</a>
9	V							<a href="#">9</a>
10	V							<a href="#">10</a>
11	V							<a href="#">11</a>
12	V							<a href="#">12</a>
13	V							<a href="#">13</a>
14	Total		\$ <a href="#">278,000</a>			\$ <a href="#">280,739</a>	\$ * <a href="#">2,739</a>	<a href="#">14</a>

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

Facility Name & ID Number      The Willow of Anna, Inc.      #      0040881      Report Period Beginning:      01/01/00      Ending:      12/31/00

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Brandman		Administrative	5.00	38,400	2.2	4.50	ABS Salary	\$ 3,770	17-7	1
2	David Abell		Administrative	9.50	57,368	5	10.00	ABS Salary	5,632	17-7	2
3	Tamar Abell		Administrative	9.50	25,497	3.5	7.25	ABS Salary	2,503	17-7	3
4	Joseph Brandman		Administrative	19.00	50,516	4	8.25	ABS Salary	4,959	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,864		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 The Willow of Anna, Inc. # 0040881 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ABS Management, Inc.  
 Street Address 2711 W. Howard  
 City / State / Zip Code Chicago, IL 60645  
 Phone Number ( 773-338-4400  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Sam Brandman	783		\$ 42,170	\$ 42,170	70	\$ 3,770	1
2	17	David Abell	783		63,000	63,000	70	5,632	2
3	17	Tamar Abell	783		28,000	28,000	70	2,503	3
4	17	Joseph Brandman	783		55,475	55,475	70	4,959	4
5	21	Clerical	783		188,161	188,161	70	16,822	5
6	6	Repairs & Maintenance	783		9,709		70	868	6
7	34	Rent	783		40,065		70	3,582	7
8	22	Health & Welfare	783		34,572		70	3,091	8
9	26	Insurance	783		10,252		70	917	9
10	21	Office	783		104,052		70	9,302	10
11	19	Professional Fees	783		12,963		70	1,159	11
12	22	Payroll Taxes	783		33,968		70	3,037	12
13	5	Utilities	783		6,118		70	547	13
14	25	Auto & Travel	783		33,961		70	3,036	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 662,466	\$ 376,806		\$ 59,225	25

Facility Name & ID Number The Willow of Anna, Inc.# 0040881

Report Period Beginning:

01/01/00

Ending:

12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			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			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		American National Bank		X	Mortgage	\$21,105.00	08/11/98	\$ 2,600,000	\$ 2,466,165		7.6600	\$ 191,078	1						
2													2						
3													3						
4													4						
5													5						
		<b>Working Capital</b>																	
6													6						
7													7						
8													8						
9		<b>TOTAL Facility Related</b>				\$21,105.00		\$ 2,600,000	\$ 2,466,165			\$ 191,078	9						
		<b>B. Non-Facility Related*</b>																	
10		Interest Income										(2,553)	10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (2,553)	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 2,600,000	\$ 2,466,165			\$ 188,525	15						

\* 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 The Willow of Anna, Inc.# 0040881 Report Period Beginning:01/01/00 Ending:12/31/00

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,000 B. General Construction Type: Exterior Frame Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: 90,771 2. Number of Years Over Which it is Being Amortized: 153. Current Period Amortization: 6,919 4. Dates Incurred: 03/01/95Nature of Costs: Organization Costs, Mortgage Costs

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1995	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

Facility Name & ID Number The Willow of Anna, Inc.

# 0040881

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	70		1995		\$ 1,080,000	\$ 27,692	39	\$ 27,692	\$	\$ 160,383	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Generator		1998		21,148	543	39	543		1,267	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	<b>TOTAL (lines 4 thru 35)</b>				\$ 1,101,148	\$ 28,235		\$ 28,235	\$	\$ 161,650	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.

Facility Name & ID Number The Willow of Anna, Inc.

# 0040881

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 350,000	\$ 32,104	\$ 35,000	\$ 2,896	10	\$ 204,167	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 350,000	\$ 32,104	\$ 35,000	\$ 2,896		\$ 204,167	41

D. Vehicle Depreciation (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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,501,148	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 60,339	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 63,235	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 2,896	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 365,817	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from ABS Management				3,582			5
6								6
7	<b>TOTAL</b>				\$ 3,582			7

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO
16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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	Exceptional Care Program													12
13	Other (specify):													13
14	<b>TOTAL</b>			\$		\$	\$		\$		\$			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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number      The Willow of Anna, Inc.

#      0040881

Report Period Beginning:      01/01/00

Ending:

12/31/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      12/31/00

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ (210)	\$ 4,990	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	305,033	305,033	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	40,264	40,264	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	30,000		8
9 Other(specify): <b>Due from Others</b>	338,705	1,025,932	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 713,792	\$ 1,376,219	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		50,000	13
14 Buildings, at Historical Cost		1,080,000	14
15 Leasehold Improvements, at Historical Cost	21,148	21,148	15
16 Equipment, at Historical Cost		350,000	16
17 Accumulated Depreciation (book methods)	(1,267)	(463,493)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	13,521	90,771	19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(13,508)	(29,725)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 19,894	\$ 1,098,701	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 733,686	\$ 2,474,920	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 40,401	\$ 40,401	26
27 Officer's Accounts Payable		30,000	27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	37,260	37,260	30
31 Accrued Taxes Payable (excluding real estate taxes)	4,434	4,434	31
32 Accrued Real Estate Taxes(Sch.IX-B)		23,316	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <b>Accrued Management Fees</b>	27,390	27,390	36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 109,485	\$ 162,801	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable		2,466,165	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,466,165	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 109,485	\$ 2,628,966	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 624,201	\$ (154,046)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 733,686	\$ 2,474,920	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 480,647	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 480,647	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	183,554	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	(40,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 143,554	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 624,201	24 *

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

Facility Name &amp; ID Number The Willow of Anna, Inc.

# 0040881

Report Period Beginning: 01/01/00

Ending: 12/31/00

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,769,808	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,769,808	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,292	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,292	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,772,100	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	404,318	31
32	Health Care	476,173	32
33	General Administration	389,416	33
<b>B. Capital Expense</b>			
34	Ownership	278,981	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	38,430	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,587,318	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	184,782	41
42	<b>Income Taxes</b>	(1,228)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 183,554	43

\* 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 **The Willow of Anna, Inc.**

# **0040881**

Report Period Beginning: **01/01/00**

Ending:

**12/31/00**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,240	\$ 33,957	\$ 15.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,518	6,790	78,542	11.57	3
4	Licensed Practical Nurses	8,922	9,397	100,982	10.75	4
5	Nurse Aides & Orderlies	30,913	32,181	204,952	6.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,905	3,087	18,141	5.88	10
11	Social Service Workers	2,015	2,182	13,760	6.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,655	13,386	78,356	5.85	15
16	Dishwashers					16
17	Maintenance Workers	2,022	2,182	15,757	7.22	17
18	Housekeepers	13,044	13,557	74,785	5.52	18
19	Laundry	5,690	5,975	33,760	5.65	19
20	Administrator	2,176	2,431	55,546	22.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,149	3,278	31,353	9.56	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)					33
34	TOTAL (lines 1 - 33)	92,089	96,686	\$ 739,891 *	\$ 7.65	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	125	\$ 4,487	1-3	35
36	Medical Director	30	1,500	9-3	36
37	Medical Records Consultant	60	1,719	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	1,599	10-3	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	40	1,509	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	\$ 10,814		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
C. Dillon	Administrator	0	\$ 55,546	Workers' Compensation Insurance	\$ 36,108	IDPH License Fee	\$ 200	
				Unemployment Compensation Insurance	8,123	Advertising: Employee Recruitment	3,126	
				FICA Taxes	57,892	Health Care Worker Background Check		
				Employee Health Insurance	9,580	(Indicate # of checks performed _____)		
				Employee Meals	3,650	Advertising	5,470	
				Illinois Municipal Retirement Fund (IMRF)*		ICLTC-Dues	3,156	
						Law Publications	529	
						Il Counties	130	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 55,546			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	(5,470)	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,141	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)				
			\$	\$ 115,353				
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type	Amount						
Mendel S. Schneider	Accounting	\$ 8,300					In-State Travel	
ABS Management	Home Office	106,189					Eastside Express-Gas1198	
Personnel Planners	U.C. Tax Consultant	923					Cheryl Dillon-759	
Sachnoff & Weaver	Legal	470					Pro1 Body Shop-810	
Mayer Magence	Legal	1,550					Seminar Expense	
							Division of Cont. Education	660
							Reppert Publications	371
							Misc.	1,627
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,658
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 117,432					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number The Willow of Anna, Inc.# 0040881Report Period Beginning: 01/01/00Ending: 12/31/00**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=3156
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No 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 of Public Aid during this cost report period. \$ 38,430  
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 of Public Aid, 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. \$ 3,650 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
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? No  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.