

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0036533

Facility Name: Willow Crest Nursing Pavilion

Address: 515 North Main Sandwich 60548
 Number City Zip Code

County: Dekalb

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

HFS ID Number: 363718794001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____
Paid Preparer	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion# 0036533 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	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	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>8</u>	Intermediate (ICF)	<u>8</u>	<u>2,920</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,340</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>3,189</u>	<u>3,743</u>	<u>5,186</u>	<u>12,118</u>	8
9	SNF/PED					9
10	ICF	<u>16,367</u>	<u>4,297</u>	<u>919</u>	<u>21,583</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,556</u>	<u>8,040</u>	<u>6,105</u>	<u>33,701</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.60%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. 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 08/01/1990

J. Was the facility purchased or leased after January 1, 1978?

YES Date 08/01/1990 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 105 and days of care provided 5,160Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	198,490	19,568	9,048	227,106		227,106	227,106			1
2	Food Purchase		170,788		170,788	(19,035)	151,753	(405)	151,348		2
3	Housekeeping		16,727	117,324	134,051		134,051		134,051		3
4	Laundry		19,356	78,216	97,572		97,572		97,572		4
5	Heat and Other Utilities			118,127	118,127		118,127	840	118,967		5
6	Maintenance	69,562	69,617	49,683	188,862		188,862	11,753	200,615		6
7	Other (specify):*							561	561		7
8	TOTAL General Services	268,052	296,056	372,398	936,506	(19,035)	917,471	12,749	930,220		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	1,673,934	53,859	22,463	1,750,256		1,750,256	(185)	1,750,071		10
10a	Therapy		1,116		1,116		1,116		1,116		10a
11	Activities	79,761	9,709	1,936	91,406		91,406		91,406		11
12	Social Services	56,500		2,508	59,008		59,008		59,008		12
13	CNA Training										13
14	Program Transportation			2,820	2,820		2,820		2,820		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,810,195	64,684	30,927	1,905,806		1,905,806	(185)	1,905,621		16
	C. General Administration										
17	Administrative	90,627			90,627		90,627	87,517	178,144		17
18	Directors Fees										18
19	Professional Services			375,096	375,096		375,096	(345,961)	29,135		19
20	Dues, Fees, Subscriptions & Promotions			70,179	70,179		70,179	(59,323)	10,856		20
21	Clerical & General Office Expenses	25,084	2,375	143,575	171,034		171,034	(62,417)	108,617		21
22	Employee Benefits & Payroll Taxes			324,558	324,558	19,035	343,593		343,593		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,436	2,436		2,436	229	2,665		24
25	Other Admin. Staff Transportation			660	660		660	1,223	1,883		25
26	Insurance-Prop.Liab.Malpractice			91,539	91,539		91,539	1,726	93,265		26
27	Other (specify):*							26,694	26,694		27
28	TOTAL General Administration	115,711	2,375	1,008,043	1,126,129	19,035	1,145,164	(350,312)	794,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,193,958	363,115	1,411,368	3,968,441		3,968,441	(337,748)	3,630,693		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Willow Crest Nursing Pavilion #0036533 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			65,164	65,164	65,164	145,157	210,321			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			24,148	24,148	24,148	43,708	67,856			32
33	Real Estate Taxes			50,632	50,632	50,632	2,970	53,602			33
34	Rent-Facility & Grounds			480,000	480,000	480,000	(480,000)				34
35	Rent-Equipment & Vehicles			6,086	6,086	6,086	6,394	12,480			35
36	Other (specify):*										36
37	TOTAL Ownership			626,030	626,030	626,030	(281,771)	344,259			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	161,060	177,879	1,800	340,739	340,739	(8,800)	331,939			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			63,510	63,510	63,510		63,510			42
43	Other (specify):*	27,975			27,975	27,975	(27,975)				43
44	TOTAL Special Cost Centers	189,035	177,879	65,310	432,224	432,224	(36,775)	395,449			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,382,993	540,994	2,102,708	5,026,695	5,026,695	(656,294)	4,370,401			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	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	77,703	30		9
10	Interest and Other Investment Income	(224)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(405)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(434)	21		18
19	Entertainment				19
20	Contributions	(1,629)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,122)	21		24
25	Fund Raising, Advertising and Promotional	(56,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,075)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,077)	20		28
29	Other-Attach Schedule	(48,886)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,104)		\$	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	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)	(514,190)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (514,190)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (656,294)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0036533
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Bank Charges	(120)
2	Marketing Salary	(27,975)
3	Franchise Tax-Bank Charge- Building Company	(202)
4	Replacement Tax- Building Company	(5,141)
5	Accounting Fees- Building Company	(900)
6	Amortization- Building Company	(3,350)
7	Radiology- Prior Period Adjustment	(3,222)
8	Pharmacy- Prior Period Adjustment	(5,552)
9	Office Expense- Prior Period Adjustment	(888)
10	R.E.M.- Prior Period Adjustment	(597)
11	Professional Services- Prior Period Adjustment	(407)
12	New Allowable Legal	(225)
13	Annual Report	(307)
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101	Total	(48,886)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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													1
2	Food Purchase	(405)											(405)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			840									840	5
6	Maintenance	(597)		6,587	5,763								11,753	6
7	Other (specify):*					561							561	7
8	TOTAL General Services	(1,002)		7,427	5,763	561							12,749	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records						(185)						(185)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs						(185)						(185)	16
	C. General Administration													
17	Administrative				87,517								87,517	17
18	Directors Fees													18
19	Professional Services	(1,532)	900	(345,329)									(345,961)	19
20	Fees, Subscriptions & Promotions	(59,968)		645									(59,323)	20
21	Clerical & General Office Expenses	(116,982)	5,343	42,896	6,326								(62,417)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			229									229	24
25	Other Admin. Staff Transportation			1,223									1,223	25
26	Insurance-Prop.Liab.Malpractice			1,726									1,726	26
27	Other (specify):*			8,785		17,909							26,694	27
28	TOTAL General Administration	(178,482)	6,243	(289,825)	93,843	17,909							(350,312)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,484)	6,243	(282,398)	99,606	18,470	(185)						(337,748)	29

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	77,703	65,250	2,204									145,157	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(224)	41,410	2,522									43,708	32
33	Real Estate Taxes			2,970									2,970	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,394									6,394	35
36	Other (specify):*	(3,350)	3,350											36
37	TOTAL Ownership	74,129	(369,990)	14,090									(281,771)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,774)					(26)						(8,800)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(27,975)											(27,975)	43
44	TOTAL Special Cost Centers	(36,749)					(26)						(36,775)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(142,104)	(363,747)	(268,308)	99,606	18,470	(211)						(656,294)	45

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
See Attached		See Attached		See Attached		
				Willow Crest Building, LLC		Building Co.

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 480,000	Willow Crest Building, LLC	100.00%	\$	\$ (480,000)	1
2	V	32 Interest Income	1,946	Willow Crest Building, LLC	100.00%		(1,946)	2
3	V	32 Interest Expense- Chase Bank		Willow Crest Building, LLC	100.00%	43,356	43,356	3
4	V	21 Franchise Tax		Willow Crest Building, LLC	100.00%	250	250	4
5	V	21 State Replcement Tax		Willow Crest Building, LLC	100.00%	5,141	5,141	5
6	V	19 Accounting Fees		Willow Crest Building, LLC	100.00%	900	900	6
7	V	30 Depreciation Expense		Willow Crest Building, LLC	100.00%	65,250	65,250	7
8	V	36 Amortization of Org. Costs		Willow Crest Building, LLC	100.00%	3,350	3,350	8
9	V	21 Bank Charges		Willow Crest Building, LLC	100.00%	(48)	(48)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 481,946			\$ 118,199	\$ * (363,747)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion# 0036533Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 840	\$ 840	15
16	V	6 REPAIRS & MAINT.				6,587	6,587	16
17	V	19 PROFESSIONAL FEES				2,379	2,379	17
18	V	20 DUES AND SUBSCRIPTIONS				645	645	18
19	V	21 CLERICAL & GENERAL				42,896	42,896	19
20	V	24 SEMINARS AND TRAVEL				229	229	20
21	V	25 AUTO EXP.				1,223	1,223	21
22	V	26 INSURANCE				1,726	1,726	22
23	V	27 EMP.BEN. - GEN. ADMIN.				8,785	8,785	23
24	V	30 DEPRECIATION				2,204	2,204	24
25	V	32 INTEREST				2,522	2,522	25
26	V	33 REAL ESTATE TAXES				2,970	2,970	26
27	V	35 EQUIPMENT RENTAL				6,394	6,394	27
28	V							28
29	V							29
30	V							30
31	V	19 BOOKKEEPING SERVICES	347,708				(347,708)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 347,708			\$ 79,400	\$ * (268,308)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,763	\$ 5,763	15
16	V	10 DON SALARY - NON-OWNER						16
17	V	17 ADMIN. CMP. - M. MAUER				15,640	15,640	17
18	V	17 ADMIN. CMP. - M. AARON				17,881	17,881	18
19	V	17 ADMIN. CMP. - F. AARON				19,050	19,050	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17 ADMIN. CMP. - S. KOPLIN						21
22	V	17 ADMIN. CMP. - D. MAGAFAS				10,503	10,503	22
23	V	17 ADMIN. CMP. - HOWARD ALTER						23
24	V	17 ADMIN. CMP. - NON-OWNER				9,717	9,717	24
25	V	17 ADMIN. CMP. - CFO NON OWNER				14,726	14,726	25
26	V	21 CLERICAL CMP. - S. AARON				6,326	6,326	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 99,606	\$ * 99,606	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 561	\$ 561	15
16	V	15 EMP. BEN - DON SALARY- NON OWNER						16
17	V	27 EMP. BEN.- M. MAUER				1,141	1,141	17
18	V	27 EMP. BEN.- M. AARON				1,500	1,500	18
19	V	27 EMP. BEN.- F. AARON				8,779	8,779	19
20	V	27 EMP. BEN.- S. GOLDSTEIN						20
21	V	27 EMP. BEN.- S. KOPLIN						21
22	V	27 EMP. BEN.- D. MAGAFAS				875	875	22
23	V	27 EMP. BEN.- HOWARD ALTER						23
24	V	27 EMP. BEN.- NON-OWNER				2,379	2,379	24
25	V	27 EMP. BEN.- CFO NON-OWNER				1,904	1,904	25
26	V	27 EMP. BEN. - S. AARON				1,331	1,331	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 18,470	\$ * 18,470	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	10 MEDICAL SUPPLIES	6,343	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	6,158	(185)	16
17	V	39 ANCILLARY EXPENSE	903	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	877	(26)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,246			\$ 7,035	\$ * (211)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Sharon Aaron	Shareholder	Clerical	0.56%	See Attached	3.48	8.69%	Alloc. Salary	\$ 6,326	21-07	1
2	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9.00	20.00%	Sal./AllocSal	36,050	17-01;17-07	2
3	Maurice Aaron	Shareholder	Administrative	23.79%	See Attached	3.97	7.95%	Alloc. Salary	17,881	17-07	3
4	Mashall Mauer	Shareholder	Administrative	10.78%	See Attached	3.48	6.95%	Alloc. Salary	15,640	17-07	4
5	Diania Magafas	Shareholder	Administrative	0.56%	See Attached	4.97	9.93%	Sal./AllocSal	13,503	17-01;17-07	5
6	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	3.97	9.93%	Alloc. Salary	5,763	06-07	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 95,163		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	5	UTILITIES	PATIENT DAYS	388,610	11	\$ 9,690	\$ 33,701	\$ 840	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	388,610	11	75,959	33,701	6,587	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	388,610	11	27,437	33,701	2,379	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	388,610	11	7,442	33,701	645	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	388,610	11	494,636	380,513	42,896	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	388,610	11	2,640	33,701	229	6
7	25	AUTO EXP.	PATIENT DAYS	388,610	11	14,104	33,701	1,223	7
8	26	INSURANCE	PATIENT DAYS	388,610	11	19,903	33,701	1,726	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	388,610	11	101,305	33,701	8,785	9
10	30	DEPRECIATION	PATIENT DAYS	388,610	11	25,409	33,701	2,204	10
11	32	INTEREST	PATIENT DAYS	388,610	11	29,080	33,701	2,522	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	388,610	11	34,252	33,701	2,970	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	388,610	11	73,733	33,701	6,394	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 915,590	\$ 380,513	\$ 79,400	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	58,010	4	5,763	1
2	10	DON SALARY - NON-OWNWER	WGHTD. AVG. HOURS	40	1	73,306			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	180,000	3	15,640	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	180,000	4	17,881	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	95,250	9	19,050	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	37,505			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	71,549			7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	105,666	5	10,503	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	8	97,823	4	9,717	10
11	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	169,480	4	14,726	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	72,716	3	6,326	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,153,305	\$ 1,153,304	\$ 99,606	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	5,643	4	561	1
2	15	EMP. BEN - DON SALARY- NON	WGHTD. AVG. HOURS	40	1	19,251			2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,131	3	1,141	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	15,105	4	1,500	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,896	9	8,779	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	34,284			6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,887			7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	8,807	5	875	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,120			9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	23,953	4	2,379	10
11	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	21,910	4	1,904	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,300	3	1,331	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 228,287	\$	\$ 18,470	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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									1
2	10	MEDICAL SUPPLIES						6,158	2
3	39	ANCILLARY EXPENSE						877	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 7,035	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Ford Credit		X	Van			\$	\$ 16,738			\$ 1,453	1
2	Chase		X	Mortgage				463,706			43,356	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Chase		X	Line of Credit				150,000			19,835	6
7	Chase		X	Note Payable							516	7
8	See Supplemental Schedule										4,866	8
9	TOTAL Facility Related						\$	\$ 630,444			\$ 70,026	9
	B. Non-Facility Related*											
10	Interest Income		X								(224)	10
11	Bldg. Co. Interest Income		X								(1,946)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(2,170)	14
15	TOTALS (line 9+line14)						\$	\$ 630,444			\$ 67,856	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number

Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term											7								
Working Capital																				
8	Insurance Financing		X				\$	\$			\$ 2,344	8								
9	Allocate: Dynamic		X								2,522	9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital										4,866	14								
B. Non-Facility Related*																				
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related											20								

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 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.)		\$ 51,602	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,602	3
4. Real Estate Tax accrual used for 2007 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.		\$ 53,602	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	60,439	8
	2003	59,388	9
	2004	49,604	10
	2005	47,064	11
	2006	48,632	12
<u>2007 Accrual: \$48,632 X 1.03 = \$50,000 (Rounded)</u>			
<u>Allocation: Dynamic \$2,970</u>			

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>19-26-433-024</u>	<u>Long Term Care Property</u>	\$ <u>48,631.58</u>	\$ <u>48,631.58</u>
2.	<u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>33,229.65</u>	\$ <u>2,881.74</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>81,861.23</u>	\$ <u>51,513.32</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533 Report Period Beginning:

01/01/07 Ending:

12/31/07

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 (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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1998</u>	<u>\$ 327,859</u>	1
2					2
3	TOTALS			\$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1990		21,410		20	1,071	1,071	18,738	9
10	Various		1991		9,997		20			9,918	10
11	Various		1992		4,279		20	214	214	3,325	11
12	Various		1993		26,868		20	1,344	1,344	19,316	12
13	Various		1994		8,312		20	416	416	5,630	13
14	Various		1995		3,234		20	162	162	2,029	14
15	Various		1996		17,411		20	870	870	9,721	15
16	Various		1997		68,499		20	3,425	3,425	34,365	16
17	Various		1998		31,645		20	1,583	1,583	15,356	17
18	Various		1999		147,088		20	7,299	7,299	61,850	18
19	Various		2000		149,982		20	7,501	7,501	56,629	19
20	Various		2001		139,226		20	6,961	6,961	44,823	20
21	Various		2002		52,106		20	4,822	4,822	37,299	21
22	Various		2003		79,602		20	7,961	7,961	36,489	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,544,733	65,250		65,250		586,969	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		38,470	986		1,099	113	15,754	68
69	Financial Statement Depreciation			30,333			(30,333)		69
70	TOTAL (lines 4 thru 69)		\$ 3,342,862	\$ 96,569		\$ 109,978	\$ 13,409	\$ 958,211	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,342,862	\$ 96,569		\$ 109,978	\$ 13,409	\$ 958,211	1
2	Elevator Work	2004	11,800		20	1,180	1,180	4,720	2
3	2Nd Floor Bathroom Improvment	2004	2,654		20	265	265	1,017	3
4	Improvements On Resident Room	2004	4,427		20	443	443	1,660	4
5	Scalcoating And Striping	2004	2,250		20	225	225	825	5
6	New Dynalock	2004	1,460		20	146	146	523	6
7	Air Conditioner	2004	1,753		20	175	175	584	7
8	Air Conditioner Unit	2004	1,753		20	175	175	701	8
9	Back Door	2004	1,190		20	119	119	476	9
10	Bathroom Remodeling	2004	1,701		20	170	170	666	10
11	Toilet And Supplies	2004	452		20	45	45	173	11
12	Toilets	2004	310		20	31	31	119	12
13	2Nd Floor Bathroom Supplies	2004	260		20	26	26	100	13
14	2Nd Floor Bathroom Supplies	2004	3,817		20	382	382	1,463	14
15	2Nd Floor Bathroom Supplies	2004	149		20	15	15	57	15
16	2Nd Floor Bathroom Supplies	2004	136		20	14	14	52	16
17	2Nd Floor Bathroom Supplies	2004	809		20	81	81	310	17
18	Tile & Fix Walls In Bathroom	2004	4,050		20	405	405	1,553	18
19	Roof Repairs	2004	7,375		20	738	738	2,827	19
20	Tile & Fix Walls In Bathrooms	2004	4,275		20	428	428	1,603	20
21	Fittings And Pipe For Water Main	2004	924		20	92	92	339	21
22	Shed	2004	954		20	95	95	310	22
23	Exit Alarm And Fall Monitor	2004	795		20	80	80	245	23
24	Exit Alarm And Fall Monitor	2004	900		20	90	90	278	24
25	Smoke Detector	2005	1,656		20	237	237	710	25
26	Smoke Detector	2005	280		20	40	40	120	26
27	Sink For Utility Room	2005	1,053		20	211	211	597	27
28	Sprinkler Repair	2005	1,137		20	114	114	313	28
29	Fire Doors And Installation	2005	2,055		20	294	294	783	29
30	Fire Doors And Installation	2005	6,001		20	857	857	2,286	30
31	Wall Air Condenser	2005	3,630		20	363	363	877	31
32	Alarm System And Remote Keys	2005	1,455		20	208	208	502	32
33	Network Cabling Jack At Office On Main Floor	2005	503		20	50	50	117	33
34	TOTAL (lines 1 thru 33)		\$ 3,414,826	\$ 96,569		\$ 117,772	\$ 21,203	\$ 985,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,414,826	\$ 96,569		\$ 117,772	\$ 21,203	\$ 985,117	1
2	Outside Camera And Digital Key Pad	2005	940		20	134	134	313	2
3	Airconditioners	2005	1,788		20	358	358	894	3
4	New Roof	2005	2,367		20	237	237	513	4
5	Roof Repairs	2005	1,400		20	140	140	303	5
6	Heating Elements	2005	870		20	87	87	189	6
7	2 Heaters	2005	3,213		20	459	459	995	7
8	Window Treatments	2005	4,540		20	454	454	946	8
9	Air Conditioner	2005	3,630		20	519	519	1,124	9
10	2 Air Conditioners	2005	3,213		20	459	459	956	10
11	Blinds	2005	1,454		20	145	145	303	11
12	Roof Repairs	2006	4,930		20	493	493	986	12
13	Water Wagon Softner	2006	2,753		20	275	275	505	13
14	Fire Equipment	2006	1,850		20	264	264	529	14
15	Roof Repairs	2006	3,260		20	326	326	571	15
16	Boiler Work	2006	1,719		20	172	172	301	16
17	Boiler Work	2006	683		20	68	68	120	17
18	Air Conditioner	2006	488		20	70	70	110	18
19	Cubicle Curtains	2006	1,316		20	132	132	186	19
20	Drywall And Caulk	2006	700		20	70	70	93	20
21	Drywall And Caulk	2006	1,000		20	100	100	133	21
22	Roof Repairs	2006	5,310		20	531	531	708	22
23	Camera	2006	325		20	46	46	62	23
24	Roof Repairs	2007	3,550		20	266	266	266	24
25	Heating And Ac Basement	2007	3,914		20	217	217	217	25
26	Roofing Materials	2007	5,678		20	331	331	331	26
27	Roofing Labor	2007	300		20	18	18	18	27
28	Roofing Labor	2007	300		20	18	18	18	28
29	Roofing Materials	2007	628		20	37	37	37	29
30	Roofing Labor	2007	1,050		20	61	61	61	30
31	Roofing Material	2007	2,733		20	159	159	159	31
32	2 A/C Heating Units	2007	3,926		20	164	164	164	32
33	Roofing Materials	2007	2,705		20	158	158	158	33
34	TOTAL (lines 1 thru 33)		\$ 3,487,359	\$ 96,569		\$ 124,740	\$ 28,171	\$ 997,386	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,487,359	\$ 96,569		\$ 124,740	\$ 28,171	\$ 997,386	1
2	Roofing Labor	2007	2,750		20	160	160	160	2
3	Roofing Materials	2007	455		20	23	23	23	3
4	3 Fans	2007	510		20	17	17	17	4
5	Repair Water System	2007	2,600		20	130	130	130	5
6	2 Ac/Heating Units	2007	3,926		20	109	109	109	6
7	Fire And Sprinkler System	2007	4,997		20	119	119	119	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12E, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12G, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	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	TOTAL (lines 1 thru 33)	\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12I, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12J, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12L, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12M, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12N, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12O, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12P, Carried Forward		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,502,597	\$ 96,569		\$ 125,298	\$ 28,729	\$ 997,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	\$ 65,250	39	\$ 65,250	\$	\$ 586,969	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	2,544,733	\$	65,250	\$	65,250	\$	586,969	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	Allocated from Dynamic Healthcare Consult.		1993	1993	\$ 38,470	\$ 986	35	\$ 1,099	\$ 113	\$ 15,754	4
5											5
6											6
7											7
8											8
Improvement Type**											
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 38,470		\$ 1,099	\$ 113	\$ 15,754	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	
71	Purchased in Prior Years	\$ 591,903	\$ 24,580	\$ 69,264	\$ 44,684	10	\$ 429,810	71
72	Current Year Purchases	37,132	6,876	4,753	(2,123)	10	4,753	72
73	Fully Depreciated Assets	494,412				10	494,412	73
74								74
75	TOTALS	\$ 1,123,447	\$ 31,456	\$ 74,017	\$ 42,561		\$ 928,975	75

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	
76		BUS	2004	\$ 44,500	\$	\$ 6,357	\$ 6,357	5	\$ 21,190	76
77		Used Van	2005	16,080	3,666	2,635	(1,031)	5	6,419	77
78		Dynamic Allocation	2007	14,954	927	2,014	1,087	5	9,918	78
79										79
80	TOTALS			\$ 75,534	\$ 4,593	\$ 11,006	\$ 6,413		\$ 37,527	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)		\$ 5,029,437	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 132,618	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 210,321	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 77,703	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,964,446	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 6,086 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocation From Dynamic Healthcare</u>		\$	\$ <u>6,394</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>6,394</u>	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 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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 CNA _____</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 CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 76,917		\$	\$		\$ 76,917	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	8,794					8,794	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	75,349					75,349	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				149,930		149,930	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					1,800	27,949		29,749	13
14	TOTAL			\$ 161,060		\$ 1,800	\$ 177,879		\$ 340,739	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 18,165	\$ 70,580	1
2	Cash-Patient Deposits	38,685	38,685	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	768,807	768,807	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,095	56,095	6
7	Other Prepaid Expenses	3,057	3,057	7
8	Accounts Receivable (owners or related parties)	(91,000)	11,600	8
9	Other(specify): See Attached Schedule	46,703	46,703	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 840,512	\$ 995,527	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	880,072	880,072	15
16	Equipment, at Historical Cost	752,509	1,158,509	16
17	Accumulated Depreciation (book methods)	(921,032)	(1,917,001)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		3,210	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 711,549	\$ 2,997,382	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,552,061	\$ 3,992,909	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 155,719	\$ 155,720	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,727	47,727	28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	224,798	224,798	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,640	3,640	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000	50,000	32
33	Accrued Interest Payable	947	2,686	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,604	11,604	35
Other Current Liabilities(specify):				
36	See Attached Schedule	23,775	65,494	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 668,210	\$ 711,669	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	16,738	16,738	39
40	Mortgage Payable		463,706	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,738	\$ 480,444	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 684,948	\$ 1,192,113	46
47	TOTAL EQUITY(page 18, line 24)	\$ 867,113	\$ 2,800,796	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,552,061	\$ 3,992,909	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 905,698	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 905,698	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(38,585)	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)	\$ (38,585)	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)	\$ 867,113	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion# 0036533Report Period Beginning: 01/01/07Ending: 12/31/07**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,831,264	1
2	Discounts and Allowances for all Levels	(980,936)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,850,328	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	820,170	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 820,170	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	213,485	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,477	19
20	Radiology and X-Ray	3,850	20
21	Other Medical Services	16,576	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 254,388	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	224	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 224	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	63,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 63,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,988,110	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	936,506	31
32	Health Care	1,905,806	32
33	General Administration	1,126,129	33
B. Capital Expense			
34	Ownership	626,030	34
C. Ancillary Expense			
35	Special Cost Centers	368,714	35
36	Provider Participation Fee	63,510	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,026,695	40
41	Income before Income Taxes (line 30 minus line 40)**	(38,585)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (38,585)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,893	2,086	\$ 60,702	\$ 29.10	1
2	Assistant Director of Nursing	1,302	1,527	46,666	30.56	2
3	Registered Nurses	5,057	5,555	156,865	28.24	3
4	Licensed Practical Nurses	20,746	23,246	595,976	25.64	4
5	CNAs & Orderlies	57,756	61,519	791,099	12.86	5
6	CNA Trainees					6
7	Licensed Therapist	4,335	4,748	161,060	33.92	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,152	40,499	18.82	9
10	Activity Assistants	5,001	5,281	39,262	7.43	10
11	Social Service Workers	2,986	3,178	56,500	17.78	11
12	Dietician					12
13	Food Service Supervisor	1,800	2,115	35,475	16.77	13
14	Head Cook	4,740	5,324	53,331	10.02	14
15	Cook Helpers/Assistants	12,861	14,936	109,684	7.34	15
16	Dishwashers					16
17	Maintenance Workers	3,078	3,391	69,562	20.51	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,824	2,190	70,627	32.25	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	20,000	9.62	22
23	Office Manager					23
24	Clerical	1,210	1,650	25,084	15.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,210	1,406	22,626	16.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	976	1,040	27,975	26.90	33
34	TOTAL (lines 1 - 33)	130,807	143,424	\$ 2,382,993 *	\$ 16.62	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	216	\$ 9,048	01-03	35
36	Medical Director	24	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	152	6,040	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,936	11-03	44
45	Social Service Consultant	43	2,508	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	475	\$ 20,732		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	Certified Nurse Assistants/Aides	762	16,423	10-03	52
53	TOTAL (lines 50 - 52)	762	\$ 16,423		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

Report Period Beginning: 01/01/07 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$6,055
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 324 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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,510
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. \$ 19,035 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? 100%ln14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? N/A If no, please explain. N/A
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT