



Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	8	Intermediate (ICF)	8	2,928	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,505	3,159	5,320	13,984	8
9	SNF/PED					9
10	ICF	15,275	3,928	37	19,240	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,780	7,087	5,357	33,224	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.26%

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)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 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 5,265

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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
	<b>A. General Services</b>										
1	Dietary	215,939	24,394	9,048	249,381		249,381	249,381			1
2	Food Purchase		197,545		197,545	(22,418)	175,128	(419)	174,709		2
3	Housekeeping		26,506	135,211	161,717		161,717		161,717		3
4	Laundry		19,242	90,141	109,383		109,383		109,383		4
5	Heat and Other Utilities			135,182	135,182		135,182	1,103	136,285		5
6	Maintenance	30,732	55,394	53,763	139,889		139,889	8,059	147,948		6
7	Other (specify):*							584	584		7
8	<b>TOTAL General Services</b>	246,671	323,081	423,345	993,097	(22,418)	970,680	9,327	980,007		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,755,700	76,954	6,280	1,838,934		1,838,934	(5,189)	1,833,745		10
10a	Therapy		3,272	19,488	22,760		22,760		22,760		10a
11	Activities	83,277	10,047	1,582	94,906		94,906		94,906		11
12	Social Services	46,915		3,670	50,585		50,585		50,585		12
13	CNA Training										13
14	Program Transportation			504	504		504		504		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,885,892	90,273	43,524	2,019,689		2,019,689	(5,189)	2,014,500		16
	<b>C. General Administration</b>										
17	Administrative	82,000			82,000		82,000	111,311	193,311		17
18	Directors Fees										18
19	Professional Services			419,694	419,694	(5,000)	414,694	(380,889)	33,805		19
20	Dues, Fees, Subscriptions & Promotions			84,967	84,967		84,967	(70,806)	14,161		20
21	Clerical & General Office Expenses	41,987	2,617	168,874	213,478		213,478	(81,839)	131,639		21
22	Employee Benefits & Payroll Taxes			378,406	378,406	22,418	400,824	(3,993)	396,831		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,778	5,778		5,778	(39)	5,739		24
25	Other Admin. Staff Transportation			1,463	1,463		1,463	2,035	3,498		25
26	Insurance-Prop.Liab.Malpractice			140,271	140,271		140,271	746	141,017		26
27	Other (specify):*							27,682	27,682		27
28	<b>TOTAL General Administration</b>	123,987	2,617	1,199,453	1,326,057	17,418	1,343,475	(395,792)	947,682		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,256,550	415,971	1,666,322	4,338,843	(5,000)	4,333,843	(391,654)	3,942,189		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: 01/01/08 Ending: 12/31/08

## 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
	<b>D. Ownership</b>										
30	Depreciation			79,640	79,640		79,640	134,389	214,029		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			23,334	23,334		23,334	17,276	40,610		32
33	Real Estate Taxes			47,033	47,033	5,000	52,033	3,771	55,804		33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)			34
35	Rent-Equipment & Vehicles			6,086	6,086		6,086	6,402	12,488		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			636,093	636,093	5,000	641,093	(318,163)	322,930		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	247,027	198,346	3,976	449,349		449,349	(3,539)	445,810		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			63,684	63,684		63,684		63,684		42
43	Other (specify):*	14,330			14,330		14,330	(14,330)			43
44	<b>TOTAL Special Cost Centers</b>	261,357	198,346	67,660	527,363		527,363	(17,869)	509,494		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,517,907	614,317	2,370,075	5,502,299		5,502,299	(727,685)	4,774,614		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: 01/01/08

Ending: 12/31/08

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	67,002	30		9
10	Interest and Other Investment Income	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(419)	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				18
19	Entertainment				19
20	Contributions	(848)	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	(111,530)	21		24
25	Fund Raising, Advertising and Promotional	(64,726)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,443)	20		28
29	Other-Attach Schedule	(59,594)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (171,593)		\$	30

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)	(556,092)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (556,092)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (727,685)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Charges	\$ (10,501)	21	1
2	Prior Period Adjustment- Radiology	(2,082)	39	2
3	Prior Period Adjustment- Office Expense	(10,223)	21	3
4	Prior Period Adjustment- R&M	(3,983)	06	4
5	Prior Period Adjustment- Other Employee Benefits	(3,993)	22	5
6	Non-Allowable Legal	(161)	19	6
7	Marketing Salary	(14,330)	43	7
8	Non-Allowable Seminar	(190)	24	8
9	COPE Dues	(4,254)	20	9
10	Franchise Tax- Building Company	(250)	21	10
11	State Replacement Tax- Building Company	(5,518)	21	11
12	Accounting Fees- Building Company	(900)	19	12
13	Amortization- Building Company	(3,210)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(59,594)		49

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(419)											(419)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,103									1,103	5
6	Maintenance	(3,983)		5,966	6,076								8,059	6
7	Other (specify):*					584							584	7
8	<b>TOTAL General Services</b>	<b>(4,402)</b>		<b>7,069</b>	<b>6,076</b>	<b>584</b>							<b>9,327</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records						(5,189)						(5,189)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>						<b>(5,189)</b>						<b>(5,189)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative				111,311								111,311	17
18	Directors Fees													18
19	Professional Services	(1,061)	900	(380,728)									(380,889)	19
20	Fees, Subscriptions & Promotions	(71,271)		465									(70,806)	20
21	Clerical & General Office Expenses	(138,022)	5,768	43,965	6,450								(81,839)	21
22	Employee Benefits & Payroll Taxes	(3,993)											(3,993)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(190)		151									(39)	24
25	Other Admin. Staff Transportation			2,035									2,035	25
26	Insurance-Prop.Liab.Malpractice			746									746	26
27	Other (specify):*			10,283		17,399							27,682	27
28	<b>TOTAL General Administration</b>	<b>(214,537)</b>	<b>6,668</b>	<b>(323,083)</b>	<b>117,761</b>	<b>17,399</b>							<b>(395,792)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(218,939)</b>	<b>6,668</b>	<b>(316,014)</b>	<b>123,837</b>	<b>17,983</b>	<b>(5,189)</b>						<b>(391,654)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	67,002	65,250	2,137									134,389	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34)	15,282	2,028									17,276	32
33	Real Estate Taxes			3,771									3,771	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,402									6,402	35
36	Other (specify):*	(3,210)	3,210											36
37	<b>TOTAL Ownership</b>	<b>63,758</b>	<b>(396,258)</b>	<b>14,338</b>									<b>(318,163)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(2,082)					(1,457)						(3,539)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,330)											(14,330)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(16,412)</b>					<b>(1,457)</b>						<b>(17,869)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(171,593)</b>	<b>(389,590)</b>	<b>(301,676)</b>	<b>123,837</b>	<b>17,983</b>	<b>(6,646)</b>						<b>(727,685)</b>	<b>45</b>

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 480,000	Willow Crest Building LLC	100.00%	\$	\$ (480,000)	1
2	V	32 Interest Income	377	Willow Crest Building LLC	100.00%		(377)	2
3	V	32 Interest Expense		Willow Crest Building LLC	100.00%	15,659	15,659	3
4	V	21 Franchise Tax		Willow Crest Building LLC	100.00%	250	250	4
5	V	21 State Replacement Tax		Willow Crest Building LLC	100.00%	5,518	5,518	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 Costs		Willow Crest Building LLC	100.00%	3,210	3,210	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,377			\$ 90,787	\$ * (389,590)	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: 01/01/08Ending: 12/31/08

## 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%	\$ 1,103	\$ 1,103	15
16	V	6 REPAIRS & MAINT.				5,966	5,966	16
17	V	19 PROFESSIONAL FEES				512	512	17
18	V	20 DUES AND SUBSCRIPTIONS				465	465	18
19	V	21 CLERICAL & GENERAL				43,965	43,965	19
20	V	24 SEMINARS AND TRAVEL				151	151	20
21	V	25 AUTO EXP.				2,035	2,035	21
22	V	26 INSURANCE				746	746	22
23	V	27 EMP.BEN. - GEN. ADMIN.				10,283	10,283	23
24	V	30 DEPRECIATION				2,137	2,137	24
25	V	32 INTEREST				2,028	2,028	25
26	V	33 REAL ESTATE TAXES				3,771	3,771	26
27	V	35 EQUIPMENT RENTAL				6,402	6,402	27
28	V							28
29	V							29
30	V	19 BOOKKEEPING	381,240				(381,240)	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		\$ 381,240			\$ 79,564	\$ * (301,676)	39

\* 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: 01/01/08Ending: 12/31/08

## 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%	\$ 6,076	\$ 6,076	15
16	V	10 DON SALARY - NON-OWNER						16
17	V	17 ADMIN. CMP. - M. MAUER				16,645	16,645	17
18	V	17 ADMIN. CMP. - M. AARON				20,564	20,564	18
19	V	17 ADMIN. CMP. - F. AARON				25,100	25,100	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17 ADMIN. CMP. - J. AARON						21
22	V	17 ADMIN. CMP. - S. KOPLIN						22
23	V	17 ADMIN. CMP. - D. MAGAFAS				14,860	14,860	23
24	V	17 ADMIN. CMP. - HOWARD ALTER						24
25	V	17 ADMIN. CMP. - NON-OWNER				19,074	19,074	25
26	V	17 ADMIN. CMP. - CFO NON OWNER				15,068	15,068	26
27	V	21 CLERICAL CMP. - S. AARON				6,450	6,450	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		\$			\$ 123,837	\$ * 123,837	39

\* 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: 01/01/08Ending: 12/31/08

## 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%	\$ 584	\$ 584	15
16	V	15 EMP. BEN - DON SALARY- NON OWNER						16
17	V	27 EMP. BEN.- M. MAUER				1,174	1,174	17
18	V	27 EMP. BEN.- M. AARON				1,662	1,662	18
19	V	27 EMP. BEN.- F. AARON				8,047	8,047	19
20	V	27 EMP. BEN.- S. GOLDSTEIN						20
21	V	27 EMP. BEN.- J. AARON						21
22	V	27 EMP. BEN.- S. KOPLIN						22
23	V	27 EMP. BEN.- D. MAGAFAS				967	967	23
24	V	27 EMP. BEN.- HOWARD ALTER						24
25	V	27 EMP. BEN.- NON-OWNER				2,576	2,576	25
26	V	27 EMP. BEN.- CFO NON-OWNER				1,772	1,772	26
27	V	27 EMP. BEN. - S. AARON				1,201	1,201	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		\$			\$ 17,983	\$ * 17,983	39

\* 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: 01/01/08Ending: 12/31/08

## 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	55,818	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	50,629	(5,189)	16
17	V	39 ANCILLARY EXPENSE	15,672	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	14,215	(1,457)	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		\$ 71,490			\$ 64,844	\$ * (6,646)	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	3.41	8.52%	Alloc. Salary	\$ 6,450	21-7	1
2	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9.00	20.00%	Sal/Alloc Sal	28,100	17-1; 17-7	2
3	Maurice Aaron	Shareholder	Administrative	23.79%	See Attached	4.22	8.44%	Alloc. Salary	20,564	17-7	3
4	Marshall Mauer	Shareholder	Administrative	10.78%	See Attached	3.41	6.82%	Alloc. Salary	16,645	17-7	4
5	Diania Magafas	Shareholder	Administrative	0.56%	See Attached	4.88	9.76%	Alloc. Salary	14,860	17-7	5
6	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	3.90	9.75%	Alloc. Salary	6,076	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,695		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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	389,945	11	\$ 12,950	\$ 33,224	\$ 1,103	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	389,945	11	70,023	33,224	5,966	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	389,945	11	6,008	33,224	512	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	389,945	11	5,456	33,224	465	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	389,945	11	516,008	397,203	43,965	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	389,945	11	1,768	33,224	151	6
7	25	AUTO EXP.	PATIENT DAYS	389,945	11	23,890	33,224	2,035	7
8	26	INSURANCE	PATIENT DAYS	389,945	11	8,755	33,224	746	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	389,945	11	120,690	33,224	10,283	9
10	30	DEPRECIATION	PATIENT DAYS	389,945	11	25,083	33,224	2,137	10
11	32	INTEREST	PATIENT DAYS	389,945	11	23,800	33,224	2,028	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	389,945	11	44,257	33,224	3,771	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	389,945	11	75,134	33,224	6,402	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					\$ 933,822	\$ 397,203	\$ 79,564	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	62,290	62,290	4	6,076	1
2	10	DON SALARY - NON-OWNWER	WGHTD. AVG. HOURS	40	1	73,680	73,680			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	195,000	195,000	3	16,645	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	195,000	195,000	4	20,564	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	125,500	125,500	9	25,100	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	72,353	72,353			6
7	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	27	1	10,176	10,176			7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	72,748	72,748			8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	152,220	152,220	5	14,860	9
10	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40		12,000	12,000			10
11	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	1	195,473	195,473	4	19,074	11
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	8	176,522	176,522	4	15,068	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	75,677	75,677	3	6,450	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					\$ 1,418,639	\$ 1,418,639		\$ 123,837	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	5,985	4	584	1
2	15	EMP. BEN - DON SALARY- NON	WGHTD. AVG. HOURS	40	1	18,419			2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,750	3	1,174	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	15,761	4	1,662	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	40,234	9	8,047	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	32,869			6
7	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	27	1	584			7
8	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	23,230			8
9	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	9,910	5	967	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,129			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	1	26,397	4	2,576	11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	8	20,765	4	1,772	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	14,086	3	1,201	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					\$ 223,119	\$	\$ 17,983	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

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						50,629	2
3	39	ANCILLARY EXPENSE						14,215	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				\$	\$		\$ 64,844	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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

**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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Ford Credit		X	Van			\$	\$ 6,167			\$ 795	1
2	Chase		X	Mortgage				25,980			15,659	2
3												3
4												4
5	See Supplemental Schedule											5
	<b>Working Capital</b>											
6	Chase		X	Line of Credit				600,000			20,897	6
7	Insurance Financing		X								1,642	7
8	See Supplemental Schedule										2,028	8
9	TOTAL Facility Related						\$	\$ 632,147			\$ 41,021	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income		X								(34)	10
11	Interest Income- Bldg. Co.		X								(377)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(411)	14
15	TOTALS (line 9+line14)						\$	\$ 632,147			\$ 40,610	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.)

\*\* 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:

01/01/08

Ending:

12/31/08

**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										
											Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	<b>TOTAL Long-Term</b>										7									
<b>Working Capital</b>																				
8	Allocated From Dynamic		X			\$	\$			\$ 2,028	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>										14									
<b>B. Non-Facility Related*</b>																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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. <u>19-26-433-024</u>	<u>Long Term Care Property</u>	\$ <u>48,033.42</u>	\$ <u>48,033.42</u>
2. <u>10-23-404-059-0000</u>	<u>Allocated From Dynamic</u>	\$ <u>38,495.99</u>	\$ <u>3,279.93</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>86,529.41</u>	\$ <u>51,313.35</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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:

01/01/08 Ending:

12/31/08

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	<b>TOTALS</b>			<b>\$ 327,859</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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
	<b>Improvement Type**</b>										
9	Various			1990	21,410		20	1,071	1,071	19,809	9
10	Various			1991	9,997		20			9,918	10
11	Various			1992	4,279		20	214	214	3,540	11
12	Various			1993	26,868		20	1,344	1,344	20,660	12
13	Various			1994	8,312		20	416	416	6,046	13
14	Various			1995	3,234		20	162	162	2,191	14
15	Various			1996	17,411		20	870	870	10,590	15
16	Various			1997	68,499		20	3,425	3,425	37,789	16
17	Various			1998	31,645		20	1,583	1,583	16,938	17
18	Various			1999	147,088		20	7,299	7,299	69,145	18
19	Various			2000	149,982		20	7,501	7,501	64,122	19
20	Various			2001	139,226		20	6,961	6,961	51,779	20
21	Various			2002	52,106		20	4,822	4,822	42,120	21
22	Various			2003	79,602		20	7,961	7,961	44,450	22
23	Various			2004	54,194		20	5,420	5,420	26,024	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:

01/01/08

Ending:

12/31/08

**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		2,544,733	65,250		65,250	(0)	652,219	67
68		37,795	969		1,080	111	16,558	68
69			32,464			(32,464)		69
70		\$ 3,396,381	\$ 98,683		\$ 115,379	\$ 16,696	\$ 1,093,898	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,396,381	\$ 98,683		\$ 115,379	\$ 16,696	\$ 1,093,898	1
2	Smoke Detector	2005	1,656		20	237	237	946	2
3	Smoke Detector	2005	280		20	40	40	160	3
4	Sink For Utility Room	2005	1,053		20	211	211	807	4
5	Sprinkler Repair	2005	1,137		20	114	114	426	5
6	Fire Doors And Installation	2005	2,055		20	294	294	1,077	6
7	Fire Doors And Installation	2005	6,001		20	857	857	3,144	7
8	Wall Air Condenser	2005	3,630		20	363	363	1,240	8
9	Alarm System And Remote Keys	2005	1,455		20	208	208	710	9
10	Network Cabling Jack At Office On Main Floor	2005	503		20	50	50	168	10
11	Outside Camera And Digital Key Pad	2005	940		20	134	134	448	11
12	Airconditioners	2005	1,788		20	358	358	1,252	12
13	New Roof	2005	2,367		20	237	237	750	13
14	Roof Repairs	2005	1,400		20	140	140	443	14
15	Heating Elements	2005	870		20	87	87	276	15
16	2 Heaters	2005	3,213		20	459	459	1,454	16
17	Window Treatments	2005	4,540		20	454	454	1,400	17
18	Air Conditioner	2005	3,630		20	519	519	1,642	18
19	2 Air Conditioners	2005	3,213		20	459	459	1,415	19
20	Blinds	2005	1,454		20	145	145	448	20
21	Roof Repairs	2006	4,930		20	493	493	1,479	21
22	Water Wagon Softner	2006	2,753		20	275	275	780	22
23	Fire Equipment	2006	1,850		20	264	264	793	23
24	Roof Repairs	2006	3,260		20	326	326	897	24
25	Boiler Work	2006	1,719		20	172	172	473	25
26	Boiler Work	2006	683		20	68	68	188	26
27	Air Conditioner	2006	488		20	70	70	180	27
28	Cubicle Curtains	2006	1,316		20	132	132	318	28
29	Drywall And Caulk	2006	700		20	70	70	163	29
30	Drywall And Caulk	2006	1,000		20	100	100	233	30
31	Roof Repairs	2006	5,310		20	531	531	1,239	31
32	Camera	2006	325		20	46	46	108	32
33	Roof Repairs	2007	3,550		20	355	355	621	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,465,450	\$ 98,683		\$ 123,647	\$ 24,964	\$ 1,119,576	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,465,450	\$ 98,683		\$ 123,647	\$ 24,964	\$ 1,119,576	1
2	Heating And Ac Basement	2007	3,914		20	326	326	544	2
3	Roofing Materials	2007	5,678		20	568	568	899	3
4	Roofing Labor	2007	300		20	30	30	48	4
5	Roofing Labor	2007	300		20	30	30	48	5
6	Roofing Materials	2007	628		20	63	63	99	6
7	Roofing Labor	2007	1,050		20	105	105	166	7
8	Roofing Material	2007	2,733		20	273	273	433	8
9	2 A/C Heating Units	2007	3,926		20	327	327	491	9
10	Roofing Materials	2007	2,705		20	270	270	428	10
11	Roofing Labor	2007	2,750		20	275	275	435	11
12	Roofing Materials	2007	455		20	45	45	68	12
13	3 Fans	2007	510		20	102	102	153	13
14	Repair Water System	2007	2,600		20	260	260	390	14
15	2 Ac/Heating Units	2007	3,926		20	327	327	436	15
16	Fire And Sprinkler System	2007	4,997		20	714	714	833	16
17	3 Fire Alarms	2008	1,170		20	153	153	153	17
18	Dual Boiler System	2008	29,523		20	2,706	2,706	2,706	18
19	Alternator Energy Solution Generator Repairs	2008	1,480		20	74	74	74	19
20	Added Outdoor Lights	2008	3,350		20	168	168	168	20
21	Sprinkler Head Installation In Basement Laundry & First Floor La	2008	2,273		20	189	189	189	21
22	Upgraded Fire Alarm System	2008	14,529		20	1,038	1,038	1,038	22
23	Rebuilt Walk-In Cooler	2008	3,215		20	107	107	107	23
24	Fence	2008	855		20	21	21	21	24
25	Sidewalk Repair	2008	825		20	21	21	21	25
26	Air Conditioner Units	2008	4,141		20	138	138	138	26
27	Fire Alarm Systems	2008	1,190		20	40	40	40	27
28	Fire Alarm And Sprinkler Syst	2008	3,651		20	122	122	122	28
29	Bathroom Improvements	2008	7,490		20	125	125	125	29
30	Air Conditioner Units	2008	4,141		20	69	69	69	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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 12H, Carried Forward		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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30									30
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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 12K, Carried Forward		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12L, Carried Forward</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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
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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)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

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		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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)		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12P, Carried Forward</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,579,755	\$ 98,683		\$ 132,333	\$ 33,650	\$ 1,130,018	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:

01/01/08

Ending:

12/31/08

**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	\$ (0)	\$ 652,219	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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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:

01/01/08

Ending:

12/31/08

**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	\$ (0)	\$ 652,219	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:

01/01/08

Ending:

12/31/08

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		1993	1993	\$ 37,795	\$ 969	35	\$ 1,080	\$ 111	\$ 16,558	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:

01/01/08

Ending:

12/31/08

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ 37,795		\$ 1,080	\$ 111	\$ 16,558	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: 01/01/08 Ending: 12/31/08

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	\$ 552,946	\$ 20,451	\$ 63,992	\$ 43,541	10	\$ 423,067	71
72	Current Year Purchases	53,264	24,599	5,563	(19,036)	10	5,563	72
73	Fully Depreciated Assets	569,981		420	420	10	569,896	73
74								74
75	TOTALS	\$ 1,176,191	\$ 45,050	\$ 69,975	\$ 24,925		\$ 998,526	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	Facility	BUS	2004	\$ 44,500	\$	\$ 6,357	\$ 6,357	5	\$ 27,548	76
77	Facility	Used Van	2005	16,080	2,200	2,070	(130)	5	8,489	77
78		Allocated From Dynamic	2008	23,897	1,094	3,294	2,200	5	13,038	78
79										79
80	TOTALS			\$ 84,477	\$ 3,294	\$ 11,721	\$ 8,427		\$ 49,075	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)	\$ 5,168,282	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,027	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,029	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,002	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,177,619	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	<b>TOTAL</b>				\$			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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>Allocated From Dynamic</u>		\$	\$ <u>6,402</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <u>6,402</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$ 103,053		\$	\$		\$ 103,053	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	20,879					20,879	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	123,095					123,095	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				148,563		148,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					3,976	49,783		53,759	13
14	TOTAL			\$ 247,027		\$ 3,976	\$ 198,346		\$ 449,349	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 &amp; ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (51,898)	\$ 31,161	1
2	Cash-Patient Deposits	27,613	27,613	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,172,928	1,172,928	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,456	44,456	6
7	Other Prepaid Expenses	3,541	3,541	7
8	Accounts Receivable (owners or related parties)		120,800	8
9	Other(specify): <a href="#">See Attached Schedule</a>	111,346	111,346	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,307,986	\$ 1,511,845	10
<b>B. Long-Term Assets</b>				
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	957,905	957,905	15
16	Equipment, at Historical Cost	805,772	1,211,772	16
17	Accumulated Depreciation (book methods)	(1,035,416)	(2,096,635)	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): <a href="#">See Attached Schedule</a>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 728,261	\$ 2,945,634	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,036,247	\$ 4,457,479	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 346,672	\$ 346,672	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,318	45,318	28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	161,145	161,145	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,181	3,181	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000	49,000	32
33	Accrued Interest Payable	3,167	3,258	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,013	6,013	35
<b>Other Current Liabilities(specify):</b>				
36	<a href="#">See Attached Schedule</a>	114,008	167,694	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,328,504	\$ 1,382,281	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	6,167	6,167	39
40	Mortgage Payable		25,981	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 6,167	\$ 32,148	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,334,671	\$ 1,414,429	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 701,576	\$ 3,043,050	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,036,247	\$ 4,457,479	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 867,113	1
2	Restatements (describe):		2
3	Depreciation & Other Late Journal Entries	(29,663)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 837,450	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(135,874)	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)	\$ (135,874)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 701,576	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,066,297	1
2	Discounts and Allowances for all Levels	(1,323,436)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,742,861	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,214,030	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,214,030	8
<b>C. Other Operating Revenue</b>			
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	222,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,138	19
20	Radiology and X-Ray	4,627	20
21	Other Medical Services	57,060	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 299,500	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 34	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	110,000	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 110,000	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,366,425	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	993,097	31
32	Health Care	2,019,689	32
33	General Administration	1,326,057	33
<b>B. Capital Expense</b>			
34	Ownership	636,093	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	463,679	35
36	Provider Participation Fee	63,684	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,502,299	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(135,874)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (135,874)	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:

01/01/08

Ending:

12/31/08

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	1,905	2,131	\$ 65,479	\$ 30.73	1
2	Assistant Director of Nursing	1,930	2,294	64,939	28.31	2
3	Registered Nurses	6,702	7,471	231,384	30.97	3
4	Licensed Practical Nurses	18,632	20,340	540,994	26.60	4
5	CNAs & Orderlies	62,105	65,721	817,641	12.44	5
6	CNA Trainees					6
7	Licensed Therapist	7,130	8,038	247,027	30.73	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,919	2,135	41,054	19.23	9
10	Activity Assistants	4,815	5,014	42,223	8.42	10
11	Social Service Workers	2,712	2,973	46,915	15.78	11
12	Dietician					12
13	Food Service Supervisor	1,845	2,153	37,732	17.53	13
14	Head Cook	4,453	4,681	51,135	10.92	14
15	Cook Helpers/Assistants	13,423	14,801	127,072	8.59	15
16	Dishwashers					16
17	Maintenance Workers	2,519	2,579	30,732	11.92	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,791	2,203	79,000	35.86	20
21	Assistant Administrator					21
22	Other Administrative	91	91	3,000	32.97	22
23	Office Manager					23
24	Clerical	2,594	2,822	41,987	14.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,984	2,196	35,263	16.06	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	392	476	14,330	30.11	33
34	TOTAL (lines 1 - 33)	136,942	148,119	\$ 2,517,907 *	\$ 17.00	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	240	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	171	6,280	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	390	19,488	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,582	11-03	44
45	Social Service Consultant	62	3,670	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,111	\$ 52,068		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			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

# 0036533

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Pamela Ingold	Administrator	0.00%	\$ 79,000	Workers' Compensation Insurance	\$ 71,855	IDPH License Fee	\$		
Fred Aaron	Administration	13.10%	3,000	Unemployment Compensation Insurance	27,330	Advertising: Employee Recruitment	2,816		
				FICA Taxes	188,350	Health Care Worker Background Check			
				Employee Health Insurance	81,737	(Indicate # of checks performed 340 )	3,400		
				Employee Meals	22,418	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,401		
				Other Employee Benefits	5,141	Licenses & Permits	2,079		
						Advertising & Promotions	66,169		
						Allocated From Dynamic	465		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 82,000						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	5,588	
							Allocated From Dynamic	151	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,161
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Frost, Ruttenberg & Rothblatt	Accounting		\$ 19,204						
Health Data Systems, Inc	Data Processing		6,642						
Reed Smith	Legal		7,008						
Real Estate Analysis Corporation	Appraisal		5,000						
Personnel Planners	Unemployment Consult.		600						
Dynamic Healthcare Consult.	Bookkeeping		381,240						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,739
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 419,694						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
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. \$ 634 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,684  
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. \$ 22,418 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT