

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	5,895	3,687	4,401	13,983	8
9	SNF/PED					9
10	ICF	14,552	4,189	86	18,827	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,447	7,876	4,487	32,810	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.49%

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 8/1/1990 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 4,278

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	223,552	22,302	9,480	255,334		255,334		255,334		1
2	Food Purchase		177,555		177,555	(20,312)	157,243	(423)	156,819		2
3	Housekeeping		19,944	138,186	158,130		158,130		158,130		3
4	Laundry		20,295	92,124	112,419		112,419		112,419		4
5	Heat and Other Utilities			110,474	110,474		110,474	1,111	111,585		5
6	Maintenance	26,092	55,008	56,768	137,868		137,868	19,665	157,533		6
7	Other (specify):*							587	587		7
8	TOTAL General Services	249,644	295,104	407,032	951,780	(20,312)	931,468	20,940	952,407		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,663,583	62,837	5,980	1,732,400		1,732,400	(1,028)	1,731,372		10
10a	Therapy		3,641		3,641		3,641		3,641		10a
11	Activities	80,369	9,081	2,120	91,570		91,570		91,570		11
12	Social Services	43,539		2,800	46,339		46,339		46,339		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,787,491	75,559	22,900	1,885,950		1,885,950	(1,028)	1,884,922		16
	C. General Administration										
17	Administrative	90,488			90,488		90,488	108,400	198,888		17
18	Directors Fees										18
19	Professional Services			420,577	420,577	(1,700)	418,877	(389,650)	29,227		19
20	Dues, Fees, Subscriptions & Promotions			48,726	48,726		48,726	(36,541)	12,185		20
21	Clerical & General Office Expenses	49,291	2,263	183,302	234,856		234,856	(97,862)	136,994		21
22	Employee Benefits & Payroll Taxes			450,109	450,109	20,312	470,421	(10,422)	459,999		22
23	Inservice Training & Education			152	152		152		152		23
24	Travel and Seminar			3,400	3,400		3,400	484	3,884		24
25	Other Admin. Staff Transportation			3,106	3,106		3,106	455	3,561		25
26	Insurance-Prop.Liab.Malpractice			110,644	110,644		110,644	1,276	111,920		26
27	Other (specify):*							30,283	30,283		27
28	TOTAL General Administration	139,779	2,263	1,220,016	1,362,058	18,612	1,380,670	(393,577)	987,093		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,176,914	372,926	1,649,948	4,199,788	(1,700)	4,198,088	(373,665)	3,824,423		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			68,590	68,590		68,590	137,716	206,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,622	27,622		27,622	(9,287)	18,335			32
33	Real Estate Taxes			34,303	34,303	1,700	36,003	3,334	39,337			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			6,086	6,086		6,086	6,214	12,300			35
36	Other (specify):*											36
37	TOTAL Ownership			616,601	616,601	1,700	618,301	(342,023)	276,278			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	286,727	196,384	768	483,879		483,879	(20,148)	463,731			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	11,485			11,485		11,485	(11,485)				43
44	TOTAL Special Cost Centers	298,212	196,384	64,278	558,874		558,874	(31,633)	527,241			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,475,126	569,310	2,330,827	5,375,263		5,375,263	(747,321)	4,627,942			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

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (18,480)	21	1
2	COPE Dues	(3,589)	20	2
3	Building Company- Franchise Tax	(275)	21	3
4	Building Company- Replacement Tax	(5,912)	21	4
5	Building Company- Accounting Fees	(950)	19	5
6	Building Company- Bank Charges	(306)	21	6
7	Prior Period Nursing Supplies	(103)	10	7
8	Prior Period Office Expenses	(1,509)	21	8
9	Prior Period Radiology	(1,217)	39	9
10	Prior Period Employee Benefits	(10,422)	22	10
11	Prior Period Pharmacy	(18,159)	39	11
12	Prior Period Lab	(109)	39	12
13	Prior Period Interest	(1,602)	32	13
14	Intercompany Interest	(1,042)	32	14
15	Non-Allowable Legal	(9,419)	19	15
16	Marketing Salary	(11,485)	43	16
17	Additional R&M	8,035	06	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(76,544)		49

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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 & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(423)											(423)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,111									1,111	5
6	Maintenance	8,035		5,660	5,970								19,665	6
7	Other (specify):*					587							587	7
8	TOTAL General Services	7,612		6,771	5,970	587							20,940	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(103)					(925)						(1,028)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(103)					(925)						(1,028)	16
	C. General Administration													
17	Administrative				108,400								108,400	17
18	Directors Fees													18
19	Professional Services	(10,369)	950	(380,231)									(389,650)	19
20	Fees, Subscriptions & Promotions	(36,973)		432									(36,541)	20
21	Clerical & General Office Expenses	(157,674)	6,493	45,945	7,374								(97,862)	21
22	Employee Benefits & Payroll Taxes	(10,422)											(10,422)	22
23	Inservice Training & Education													23
24	Travel and Seminar			484									484	24
25	Other Admin. Staff Transportation			455									455	25
26	Insurance-Prop.Liab.Malpractice			1,276									1,276	26
27	Other (specify):*			8,922		21,361							30,283	27
28	TOTAL General Administration	(215,438)	7,443	(322,717)	115,774	21,361							(393,577)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(207,929)	7,443	(315,946)	121,744	21,948	(925)						(373,665)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	69,408	65,250	3,058									137,716	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,949)	(90)	2,752									(9,287)	32
33	Real Estate Taxes			3,334									3,334	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,214									6,214	35
36	Other (specify):*													36
37	TOTAL Ownership	57,459	(414,840)	15,358									(342,023)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(19,485)					(663)						(20,148)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(11,485)											(11,485)	43
44	TOTAL Special Cost Centers	(30,970)					(663)						(31,633)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(181,440)	(407,397)	(300,588)	121,744	21,948	(1,588)						(747,321)	45

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 Company	100.00%	\$	\$ (480,000)	1
2	V	32 Interest Income	127	Willow Crest Building Company	100.00%		(127)	2
3	V	32 Interest Expense		Willow Crest Building Company	100.00%	37	37	3
4	V	21 Franchise Tax		Willow Crest Building Company	100.00%	275	275	4
5	V	21 State replacement Tax		Willow Crest Building Company	100.00%	5,912	5,912	5
6	V	19 Accounting Fees		Willow Crest Building Company	100.00%	950	950	6
7	V	21 Bank Charges		Willow Crest Building Company	100.00%	306	306	7
8	V	30 Depreciation		Willow Crest Building Company	100.00%	65,250	65,250	8
9	V			Willow Crest Building Company	100.00%			9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,127			\$ 72,730	\$ * (407,397)	14

* 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	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,111	\$ 1,111
16	V	6 REPAIRS & MAINT.				5,660	5,660
17	V	19 PROFESSIONAL FEES				809	809
18	V	20 DUES AND SUBSCRIPTIONS				432	432
19	V	21 CLERICAL & GENERAL				45,945	45,945
20	V	24 SEMINARS AND TRAVEL				484	484
21	V	25 AUTO EXP.				455	455
22	V	26 INSURANCE				1,276	1,276
23	V	27 EMP.BEN. - GEN. ADMIN.				8,922	8,922
24	V	30 DEPRECIATION				3,058	3,058
25	V	32 INTEREST				2,752	2,752
26	V	33 REAL ESTATE TAXES				3,334	3,334
27	V	35 EQUIPMENT RENTAL				6,214	6,214
28	V						
29	V	19 BOOKKEEPING	381,040				(381,040)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 381,040			\$ 80,452	\$ * (300,588)

* 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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,970	\$	5,970	15
16	V	17 ADMIN. CMP. - M. MAUER				16,287		16,287	16
17	V	17 ADMIN. CMP. - M. AARON				18,469		18,469	17
18	V	17 ADMIN. CMP. - F. AARON				21,200		21,200	18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN							19
20	V	17 ADMIN. CMP. - J. AARON							20
21	V	17 ADMIN. CMP. - S. KOPLIN							21
22	V	17 ADMIN. CMP. - D. MAGAFAS				15,208		15,208	22
23	V	17 ADMIN. CMP. - HOWARD ALTER							23
24	V	17 ADMIN. CMP. - NON-OWNER-V. DAVIS							24
25	V	17 ADMIN. CMP. - NON-OWNER -VAR.				20,486		20,486	25
26	V	17 ADMIN. CMP. - CFO NON OWNER				16,750		16,750	26
27	V	21 CLERICAL CMP. - S. AARON				7,374		7,374	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		\$			\$ 121,744	\$ *	121,744	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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 587	\$ 587	15
16	V	27 EMP. BEN.- M. MAUER				1,169	1,169	16
17	V	27 EMP. BEN.- M. AARON				1,525	1,525	17
18	V	27 EMP. BEN.- F. AARON				8,736	8,736	18
19	V	27 EMP. BEN.- S. GOLDSTEIN						19
20	V	27 EMP. BEN.- J. AARON						20
21	V	27 EMP. BEN.- S. KOPLIN						21
22	V	27 EMP. BEN.- D. MAGAFAS				985	985	22
23	V	27 EMP. BEN.- HOWARD ALTER						23
24	V	27 EMP. BEN.-V. DAVIS						24
25	V	27 EMP. BEN.- NON-OWNER				5,781	5,781	25
26	V	27 EMP. BEN.- CFO NON-OWNER				1,853	1,853	26
27	V	27 EMP. BEN. - S. AARON				1,312	1,312	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		\$			\$ 21,948	\$ * 21,948	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	10 MEDICAL SUPPLIES	8,566	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	7,641	(925)	16
17	V	39 ANCILLARY EXPENSE	6,139	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	5,476	(663)	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		\$ 14,705			\$ 13,117	\$ * (1,588)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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: 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		
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: 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		
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: 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		
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:

01/01/09

Ending:

12/31/09

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	3.34	8.35%	Alloc. Salary	\$ 7,374	21-7	1
2	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9.00	20.00%	Sal/Alloc Sal	30,200	17-1; 17-7	2
3	Maurice Aaron	Shareholder	Administrative	23.79%	See Attached	3.79	7.58%	Alloc. Salary	18,469	17-7	3
4	Marshall Mauer	Shareholder	Administrative	10.78%	See Attached	3.34	6.68%	Alloc. Salary	16,287	17-7	4
5	Diania Magafas	Shareholder	Administrative	0.56%	See Attached	4.74	9.48%	Alloc. Salary	15,208	17-7	5
6	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	3.79	9.48%	Alloc. Salary	5,970	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,508		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	393,498	11	\$ 13,322	\$ 32,810	\$ 1,111	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	393,498	11	67,883	32,810	5,660	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	393,498	11	9,699	32,810	809	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	393,498	11	5,183	32,810	432	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	393,498	11	551,031	404,350	45,945	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	393,498	11	5,810	32,810	484	6
7	25	AUTO EXP.	PATIENT DAYS	393,498	11	5,452	32,810	455	7
8	26	INSURANCE	PATIENT DAYS	393,498	11	15,305	32,810	1,276	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	393,498	11	107,005	32,810	8,922	9
10	30	DEPRECIATION	PATIENT DAYS	393,498	11	36,672	32,810	3,058	10
11	32	INTEREST	PATIENT DAYS	393,498	11	33,003	32,810	2,752	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	393,498	11	39,991	32,810	3,334	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	393,498	11	74,530	32,810	6,214	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					\$ 964,886	\$ 404,350	\$ 80,452	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	63,031	63,031	4	5,970	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	195,000	195,000	3	16,287	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	195,000	195,000	4	18,469	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	106,000	106,000	9	21,200	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	94,542	94,542			5
6	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	40	1	2,657	2,657			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	73,196	73,196			7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	160,425	160,425	5	15,208	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	1	74,152	74,152			10
11	17	ADMIN. CMP. - NON-OWNER -	WGHTD. AVG. HOURS	45	8	216,303	216,303	4	20,486	11
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	200,543	200,543	4	16,750	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	88,338	88,338	3	7,374	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					\$ 1,481,187	\$ 1,481,188		\$ 121,744	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	6,197	4	587	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,995	3	1,169	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	16,097	4	1,525	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,678	9	8,736	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,728			5
6	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	40	1				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,540			7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	10,394	5	985	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,079			9
10	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	1	17,756			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	61,038	4	5,781	11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	22,185	4	1,853	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,719	3	1,312	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					\$ 271,406	\$	\$ 21,948	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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						7,641	2
3	39	ANCILLARY EXPENSE						5,476	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				\$	\$		\$ 13,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Chase Bank		X	Mortgage						\$ 37	1								
2	Ford Credit		X	Van						1,022	2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	MB Financial		X	Line of Credit			474,000			22,898	6								
7	Insurance Financing		X	Insurance Financing						1,058	7								
8	See Supplemental Schedule									2,752	8								
9	TOTAL Facility Related					\$	\$ 474,000			\$ 27,767	9								
B. Non-Facility Related*																			
10	Interest Income		X							(9,305)	10								
11	Interest Income- Bldg. Co.		X							(127)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$	\$			\$ (9,432)	14								
15	TOTALS (line 9+line14)					\$	\$ 474,000			\$ 18,335	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533 Report Period Beginning:

01/01/09 Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1998</u>	<u>\$ 327,859</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1990	21,410		20	1,071	1,071	20,879	9
10	Various		1991	9,997		20			9,918	10
11	Various		1992	4,279		20	214	214	3,753	11
12	Various		1993	26,868		20	1,344	1,344	22,002	12
13	Various		1994	8,312		20	416	416	6,461	13
14	Various		1995	3,234		20	162	162	2,353	14
15	Various		1996	17,411		20	870	870	11,462	15
16	Various		1997	68,499		20	3,425	3,425	41,215	16
17	Various		1998	31,645		20	1,583	1,583	18,523	17
18	Various		1999	147,088		20	7,299	7,299	76,438	18
19	Various		2000	149,982		20	7,501	7,501	71,624	19
20	Various		2001	139,226		20	6,961	6,961	58,740	20
21	Various		2002	52,106		20	2,572	2,572	44,693	21
22	Various		2003	79,602		20	7,961	7,961	52,411	22
23	Various		2004	54,194		20	5,420	5,420	31,443	23
24	Various		2005	41,185		20	5,366	5,366	23,570	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:

01/01/09

Ending:

12/31/09

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	Related Building Company (Pages 12F & 12G)	2,544,733	65,250		65,250		717,469	67
68	Related Party Allocations (Pages 12H & 12I)	36,988	948		1,057	109	17,260	68
69	Financial Statement Depreciation		44,283			(44,283)		69
70	TOTAL (lines 4 thru 69)	\$ 3,436,759	\$ 110,481		\$ 118,472	\$ 7,991	\$ 1,230,214	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,436,759	\$ 110,481		\$ 118,472	\$ 7,991	\$ 1,230,214	1
2	Roof Repairs	2006	4,930		20	493	493	1,972	2
3	Water Wagon Softner	2006	2,753		20	275	275	1,055	3
4	Fire Equipment	2006	1,850		20	264	264	1,057	4
5	Roof Repairs	2006	3,260		20	326	326	1,223	5
6	Boiler Work	2006	1,719		20	172	172	645	6
7	Boiler Work	2006	683		20	68	68	256	7
8	Air Conditioner	2006	488		20	70	70	250	8
9	Cubicle Curtains	2006	1,316		20	132	132	449	9
10	Drywall And Caulk	2006	700		20	70	70	233	10
11	Drywall And Caulk	2006	1,000		20	100	100	333	11
12	Roof Repairs	2006	5,310		20	531	531	1,770	12
13	Camera	2006	325		20	46	46	155	13
14	Roof Repairs	2007	3,550		20	355	355	976	14
15	Heating And Ac Basement	2007	3,914		20	326	326	870	15
16	Roofing Materials	2007	5,678		20	568	568	1,467	16
17	Roofing Labor	2007	300		20	30	30	78	17
18	Roofing Labor	2007	300		20	30	30	78	18
19	Roofing Materials	2007	628		20	63	63	162	19
20	Roofing Labor	2007	1,050		20	105	105	271	20
21	Roofing Material	2007	2,733		20	273	273	706	21
22	2 A/C Heating Units	2007	3,926		20	327	327	818	22
23	Roofing Materials	2007	2,705		20	270	270	699	23
24	Roofing Labor	2007	2,750		20	275	275	710	24
25	Roofing Materials	2007	455		20	45	45	114	25
26	3 Fans	2007	510		20	102	102	255	26
27	Repair Water System	2007	2,600		20	260	260	650	27
28	2 Ac/Heating Units	2007	3,926		20	327	327	763	28
29	Fire And Sprinkler System	2007	4,997		20	714	714	1,547	29
30	3 Fire Alarms	2008	1,170		20	167	167	320	30
31	Dual Boiler System	2008	29,523		20	2,952	2,952	5,658	31
32	Alternator Energy Solution Generator Repairs	2008	1,480		20	148	148	222	32
33	Added Outdoor Lights	2008	3,350		20	335	335	503	33
34	TOTAL (lines 1 thru 33)		\$ 3,536,638	\$ 110,481		\$ 128,691	\$ 18,210	\$ 1,256,479	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12B, Carried Forward		\$ 3,536,638	\$ 110,481		\$ 128,691	\$ 18,210	\$ 1,256,479	1
2	Sprinkler Head Installation In Basement Laundry & First Floor L	2008	2,273		20	325	325	514	2
3	Upgraded Fire Alarm System	2008	14,529		20	2,076	2,076	3,113	3
4	Rebuilt Walk-In Cooler	2008	3,215		20	322	322	429	4
5	Fence	2008	855		20	86	86	107	5
6	Sidewalk Repair	2008	825		20	83	83	103	6
7	Air Conditioner Units	2008	4,141		20	828	828	966	7
8	Fire Alarm Systems	2008	1,190		20	238	238	278	8
9	Fire Alarm And Sprinkler Syst	2008	3,651		20	730	730	852	9
10	Bathroom Improvements	2008	7,490		20	749	749	874	10
11	Air Conditioner Units	2008	4,141		20	828	828	897	11
12	Roof Repair	2009	9,235		20	45	45	45	12
13	Electrical Work	2009	7,865		20	132	132	132	13
14	4 Heating Air Conditioning Units	2009	8,364		20	976	976	976	14
15	Air Conditioner	2009	6,898		20	53	53	53	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,611,310	\$ 110,481		\$ 136,162	\$ 25,681	\$ 1,265,818	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:

01/01/09

Ending:

12/31/09

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	
1		\$ 3,611,310	\$ 110,481		\$ 136,162	\$ 25,681	\$ 1,265,818	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,611,310	\$ 110,481		\$ 136,162	\$ 25,681	\$ 1,265,818	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:

01/01/09

Ending:

12/31/09

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	
1		\$ 3,611,310	\$ 110,481		\$ 136,162	\$ 25,681	\$ 1,265,818	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,611,310	\$ 110,481		\$ 136,162	\$ 25,681	\$ 1,265,818	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Building Company Information								1
2	Buildings:								2
3	116 Beds	1975	2,544,733	65,250	39	65,250		717,469	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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:

01/01/09

Ending:

12/31/09

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	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,544,733	\$ 65,250		\$ 65,250	\$	\$ 717,469	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:

01/01/09

Ending:

12/31/09

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Dynamic	1993	36,988	948	35	1,057	109	17,260	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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:

01/01/09

Ending:

12/31/09

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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 36,988	\$ 948		\$ 1,057	\$ 109	\$ 17,260	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:

01/01/09

Ending:

12/31/09

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	\$ 561,420	\$ 14,076	\$ 58,286	\$ 44,210	10	\$ 442,255	71
72	Current Year Purchases	14,872	8,011	791	(7,220)	10	791	72
73	Fully Depreciated Assets	604,693		48	48	10	604,611	73
74								74
75	TOTALS	\$ 1,180,985	\$ 22,087	\$ 59,125	\$ 37,038		\$ 1,047,657	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2004	\$ 44,500	\$	\$ 6,357	\$ 6,357	5	\$ 33,905	76
77		Used Van	2005	16,080	2,220	1,959	(261)	5	10,448	77
78		Allocated From Dynamic	2009	16,509	2,109	2,702	593	5	3,452	78
79										79
80	TOTALS			\$ 77,089	\$ 4,329	\$ 11,018	\$ 6,689		\$ 47,805	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)	\$ 5,197,243	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,897	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 206,305	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,408	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,361,280	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 6,181 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>6,120</u>	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ <u>6,120</u>	21

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 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 138,099		\$			\$ 138,099	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	6,952					6,952	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	141,676					141,676	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 prescrpts				167,697		167,697	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					768	28,687		29,455	13
14	TOTAL			\$ 286,727		\$ 768	\$ 196,384		\$ 483,879	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 58,018	\$ 188,349	1
2	Cash-Patient Deposits	23,422	23,422	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	779,610	779,610	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,854	87,854	6
7	Other Prepaid Expenses	1,992	1,992	7
8	Accounts Receivable (owners or related parties)		120,800	8
9	Other(specify): See Attached Schedule	72,383	72,383	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,023,279	\$ 1,274,410	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	993,306	993,306	15
16	Equipment, at Historical Cost	833,718	1,239,718	16
17	Accumulated Depreciation (book methods)	(1,124,525)	(2,250,994)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 702,499	\$ 2,854,622	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,725,778	\$ 4,129,032	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 288,461	\$ 288,461	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,790	30,790	28
29	Short-Term Notes Payable	474,000	474,000	29
30	Accrued Salaries Payable	163,925	163,925	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,556	3,556	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000	42,000	32
33	Accrued Interest Payable	1,278	1,278	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,662	6,662	35
Other Current Liabilities(specify):				
36	See Attached Schedule	85,100	157,483	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,095,772	\$ 1,168,155	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,095,772	\$ 1,168,155	46
47	TOTAL EQUITY(page 18, line 24)	\$ 630,006	\$ 2,960,877	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,725,778	\$ 4,129,032	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 701,576	1
2	Restatements (describe):		2
3	Depreciation Adjustments	(12,434)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 689,142	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(59,136)	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)	\$ (59,136)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 630,006	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: 01/01/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,107,197	1
2	Discounts and Allowances for all Levels	(1,310,348)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,796,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,159,990	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,159,990	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	222,737	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,821	19
20	Radiology and X-Ray	4,784	20
21	Other Medical Services	29,661	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 296,003	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,305	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,305	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	53,980	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 53,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,316,127	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	951,780	31
32	Health Care	1,885,950	32
33	General Administration	1,362,058	33
B. Capital Expense			
34	Ownership	616,601	34
C. Ancillary Expense			
35	Special Cost Centers	495,364	35
36	Provider Participation Fee	63,510	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,375,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(59,136)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (59,136)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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:

01/01/09

Ending:

12/31/09

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	94	185	\$ 3,741	\$ 20.22	1
2	Assistant Director of Nursing	2,521	2,712	85,162	31.40	2
3	Registered Nurses	10,463	11,405	345,460	30.29	3
4	Licensed Practical Nurses	16,153	18,615	474,787	25.51	4
5	CNAs & Orderlies	58,553	62,870	709,921	11.29	5
6	CNA Trainees					6
7	Licensed Therapist	8,537	9,468	286,727	30.28	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,754	1,999	39,513	19.77	9
10	Activity Assistants	4,398	4,859	40,856	8.41	10
11	Social Service Workers	2,671	2,955	37,220	12.60	11
12	Dietician					12
13	Food Service Supervisor	1,817	1,969	38,913	19.76	13
14	Head Cook	4,041	4,230	45,158	10.68	14
15	Cook Helpers/Assistants	13,545	14,816	139,481	9.41	15
16	Dishwashers					16
17	Maintenance Workers	2,151	2,250	26,092	11.60	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,745	2,174	81,488	37.48	20
21	Assistant Administrator					21
22	Other Administrative	266	266	9,000	33.83	22
23	Office Manager					23
24	Clerical	2,725	3,175	49,291	15.52	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	2,209	2,466	44,512	18.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,015	1,025	17,804	17.37	33
34	TOTAL (lines 1 - 33)	134,658	147,439	\$ 2,475,126 *	\$ 16.79	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	218	\$ 9,480	01-03	35
36	Medical Director	240	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	150	5,980	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,120	11-03	44
45	Social Service Consultant	47	2,800	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	697	\$ 32,380		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

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%	\$ 81,488	Workers' Compensation Insurance	\$ 118,725	IDPH License Fee	\$	
Fred Aaron	Administration	13.10%	9,000	Unemployment Compensation Insurance	28,060	Advertising: Employee Recruitment	835	
				FICA Taxes	186,520	Health Care Worker Background Check	2,020	
				Employee Health Insurance	99,754	(Indicate # of checks performed 202)		
				Employee Meals	20,312	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,546	
				Other Employee Benefits	6,628	Advertising & Promotions	33,384	
						Licenses & Permits	2,352	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated From Dynamic	432	
(List each licensed administrator separately.)			\$ 90,488					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense (
			\$			Non-allowable advertising	(32,656)	
						Yellow page advertising	(728)	
						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 459,999		\$ 12,185	
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description			Description	
				Line #			Amount	
C. Professional Services				Description			Amount	
Vendor/Payee	Type	Amount						
Frost, Ruttenberg & Rothblatt	Accounting	\$ 10,967				Out-of-State Travel	\$	
Health Data Systems Inc.	Data Processing	9,847						
Casamba	Data Processing	2,100						
See Attached	Legal	13,778				In-State Travel		
Dynamic HC Consultants	Bookkeeping	381,040						
Personnel Planners	Unemployment Consult	1,145						
Skidelsky & Associates	Legal- RE Tax Appeal	1,700				Seminar Expense	3,401	
						Allocated From Dynamic	484	
						Entertainment Expense (
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 420,577			(agree to Sch. V, line 24, col. 8)		
					\$	TOTAL	\$ 3,885	

* 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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2006					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
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

Facility Name & ID Number Willow Crest Nursing Pavilion

0036533

Report Period Beginning:

01/01/09

Ending:

12/31/09

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. ILCLTC \$8,839; IL Assoc of HC Facilities \$1,296
- (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. \$ 240 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. \$ 63,510
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,312 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
- (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.