

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,529	1,557	5,544	9,630	8
9	SNF/PED					9
10	ICF	19,427	5,909	640	25,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,956	7,466	6,184	35,606	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.10%

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 5,447

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		487	397,596	398,083		398,083		398,083		1
2	Food Purchase		127,256		127,256	(13,414)	113,842	(265)	113,578		2
3	Housekeeping		3,155	163,100	166,255		166,255		166,255		3
4	Laundry		7,830	102,256	110,086		110,086		110,086		4
5	Heat and Other Utilities			102,947	102,947		102,947	928	103,875		5
6	Maintenance	62,241	51,001	63,846	177,088		177,088	161,689	338,777		6
7	Other (specify):*							847	847		7
8	TOTAL General Services	62,241	189,729	829,745	1,081,715	(13,414)	1,068,301	163,199	1,231,501		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,097,665	126,727	7,488	2,231,880		2,231,880		2,231,880		10
10a	Therapy		6,243		6,243		6,243		6,243		10a
11	Activities	187,685	15,099	1,664	204,448		204,448		204,448		11
12	Social Services	91,372		8,840	100,212		100,212		100,212		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,376,722	148,069	29,992	2,554,783		2,554,783		2,554,783		16
	C. General Administration										
17	Administrative	141,151			141,151		141,151	116,219	257,370		17
18	Directors Fees										18
19	Professional Services			588,134	588,134		588,134	(482,350)	105,784		19
20	Dues, Fees, Subscriptions & Promotions			142,924	142,924		142,924	(61,813)	81,111		20
21	Clerical & General Office Expenses	90,049	4,445	461,507	556,001		556,001	(303,876)	252,125		21
22	Employee Benefits & Payroll Taxes			546,972	546,972	13,414	560,386		560,386		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,953	10,953		10,953	(1,725)	9,228		24
25	Other Admin. Staff Transportation			14,310	14,310		14,310	1,946	16,256		25
26	Insurance-Prop.Liab.Malpractice			136,625	136,625		136,625	8,079	144,704		26
27	Other (specify):*							36,788	36,788		27
28	TOTAL General Administration	231,200	4,445	1,901,425	2,137,070	13,414	2,150,484	(686,732)	1,463,752		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,670,163	342,243	2,761,162	5,773,568		5,773,568	(523,532)	5,250,036		29

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

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

Facility Name & ID Number Willow Crest Nsg. Pavilion #0036533 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			185,827	185,827		185,827	273,325	459,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,118	37,118		37,118	271,456	308,574			32
33	Real Estate Taxes							45,092	45,092			33
34	Rent-Facility & Grounds			1,074,000	1,074,000		1,074,000	(1,074,000)				34
35	Rent-Equipment & Vehicles			18,800	18,800		18,800	1,361	20,161			35
36	Other (specify):*							57,954	57,954			36
37	TOTAL Ownership			1,315,745	1,315,745		1,315,745	(424,812)	890,933			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	461,588	205,042		666,630		666,630	(8,497)	658,133			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,569	246,569		246,569		246,569			42
43	Other (specify):*	28,800		1,000	29,800		29,800	(29,800)				43
44	TOTAL Special Cost Centers	490,388	205,042	247,569	942,999		942,999	(38,297)	904,702			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,160,551	547,285	4,324,476	8,032,312		8,032,312	(986,641)	7,045,671			45

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

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	139,037	30		9
10	Interest and Other Investment Income	(56,932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(265)	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	(154)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(215,831)	21		24
25	Fund Raising, Advertising and Promotional	(56,825)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(261,866)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (452,835)		\$	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)	(533,806)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (533,806)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (986,641)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Willow Crest Nsg. Pavilion

ID# 0036533

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (17,477)	21	1
2	Interest - Intercompany	(625)	32	2
3	PPA - A & G Expense	(112,310)	21	3
4	PPA - Pharmacy	(8,497)	39	4
5	Non-Allowable Legal	(20,014)	19	5
6	Building Company - Replacement Tax	(1,460)	21	6
7	Building Company - Accounting	(23,035)	19	7
8	Building Company - Legal	(300)	19	8
9	Building Company - Bank Charges	(709)	21	9
10	Building Company - Amortization	(5,238)	36	10
11	Additional R&M - Building Company	4,143	06	11
12	Sequestration Expense	(46,345)	21	12
13	Additional R&M	19,577	06	13
14	Non-Allowable Lease	(8,263)	35	14
15	Marketing Expense	(1,000)	43	15
16	Marketing Salary	(28,800)	43	16
17	PAC Dues	(7,270)	20	17
18	Non-Allowable Seminar	(4,078)	24	18
19	Non-Allowable Dues	(165)	20	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	(261,866)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(265)											(265)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			928									928	5
6	Maintenance	23,720	124,868	6,877	6,224								161,689	6
7	Other (specify):*			200		647							847	7
8	TOTAL General Services	23,455	124,868	8,005	6,224	647							163,199	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													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													16
	C. General Administration													
17	Administrative				116,219								116,219	17
18	Directors Fees													18
19	Professional Services	(43,349)	23,335	(462,336)									(482,350)	19
20	Fees, Subscriptions & Promotions	(64,260)		2,447									(61,813)	20
21	Clerical & General Office Expenses	(394,286)	2,169	79,934	8,307								(303,876)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(4,078)		2,353									(1,725)	24
25	Other Admin. Staff Transportation			1,946									1,946	25
26	Insurance-Prop.Liab.Malpractice		5,336	2,743									8,079	26
27	Other (specify):*			12,140		24,648							36,788	27
28	TOTAL General Administration	(505,973)	30,840	(360,773)	124,526	24,648							(686,732)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(482,517)	155,708	(352,768)	130,750	25,295							(523,532)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15 Ending:

12/31/15

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	139,037	132,031	2,257									273,325	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(57,557)	327,134	1,879									271,456	32
33	Real Estate Taxes		41,575	3,517									45,092	33
34	Rent-Facility & Grounds		(1,074,000)										(1,074,000)	34
35	Rent-Equipment & Vehicles	(8,263)		9,624									1,361	35
36	Other (specify):*	(5,238)	63,192										57,954	36
37	TOTAL Ownership	67,979	(510,068)	17,277									(424,812)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,497)											(8,497)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(29,800)											(29,800)	43
44	TOTAL Special Cost Centers	(38,297)											(38,297)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(452,835)	(354,360)	(335,491)	130,750	25,295							(986,641)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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)	
1	V	34 Rental Income	\$ 1,074,000	Willow Crest Building Company	100.00%	\$	\$ (1,074,000)	1
2	V	32 Interest	952	Willow Crest Building Company	100.00%	328,086	327,134	2
3	V	21 Replacement Tax		Willow Crest Building Company	100.00%	1,460	1,460	3
4	V	19 Accounting Fees		Willow Crest Building Company	100.00%	23,035	23,035	4
5	V	19 Legal Fees		Willow Crest Building Company	100.00%	300	300	5
6	V	21 Bank Charges		Willow Crest Building Company	100.00%	709	709	6
7	V	06 Repairs and Maintenance		Willow Crest Building Company	100.00%	124,868	124,868	7
8	V	33 Real Estate Taxes		Willow Crest Building Company	100.00%	41,575	41,575	8
9	V	26 Insurance Expense		Willow Crest Building Company	100.00%	5,336	5,336	9
10	V	36 MIP Expense		Willow Crest Building Company	100.00%	57,954	57,954	10
11	V	30 Depreciation		Willow Crest Building Company	100.00%	132,031	132,031	11
12	V	36 Amortization Expense		Willow Crest Building Company	100.00%	5,238	5,238	12
13	V							13
14	Total		\$ 1,074,952			\$ 720,592	\$ * (354,360)	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%	\$ 928	\$	928	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	6,877		6,877	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	200		200	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	2,664		2,664	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	2,447		2,447	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	79,934		79,934	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	2,353		2,353	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,946		1,946	22
23	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	2,743		2,743	23
24	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	12,140		12,140	24
25	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	2,257		2,257	25
26	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,879		1,879	26
27	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,517		3,517	27
28	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%				28
29	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	9,557		9,557	29
30	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	67		67	30
31	V								31
32	V	19 HOME OFFICE	465,000	DYNAMIC HEALTH CARE CONS.	100.00%			(465,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 465,000			\$ 129,509	\$ *	(335,491)	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 6,224	\$ 6,224
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	18,400	18,400
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	20,965	20,965
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,100	1,100
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	18,055	18,055
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%		
21	V	17 ADMIN. CMP. - B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%		
22	V	17 ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%		
23	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%		
24	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	15,454	15,454
25	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%		
26	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	10,561	10,561
27	V	17 ADMIN. CMP. - A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%		
28	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	13,740	13,740
29	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	17,944	17,944
30	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,713	7,713
31	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	594	594
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 130,750	\$ * 130,750

* 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%	\$ 647	\$	647	15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	1,059		1,059	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,482		1,482	17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,852		7,852	18
19	V	27 EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,457		1,457	19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	27 EMP. BEN.- B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	27 EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				22
23	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	1,101		1,101	24
25	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				25
26	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,951		2,951	26
27	V	27 EMP. BEN.-A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%				27
28	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	4,534		4,534	28
29	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,280		2,280	29
30	V	27 EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,587		1,587	30
31	V	27 EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	345		345	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 25,295	\$ *	25,295	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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:	
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.

Facility Name & ID Number

Willow Crest Nsg. Pavilion

#

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Marshall Mauer	Shareholder	Administrative	10.78%	See Attached	3.68	7.36%	Alloc. Salary	\$ 18,400	17-07	1	
2	Maury Aaron	Shareholder	Administrative	23.79%	See Attached	4.19	8.39%	Alloc. Salary	20,965	17-07	2	
3	Diania Kufita	Shareholder	Administrative	0.56%	See Attached	5.24	10.48%	Alloc. Salary	15,454	17-07	3	
4	Esther Maryles	Shareholder	Clerical	6.05%	See Attached	0.26	0.92%	Alloc. Salary	594	21-07	4	
5	Dennis Nehmer	Shareholder	Maintenance	0.56%	See Attached	4.19	10.48%	Alloc. Salary	6,224	06-07	5	
6	Sharon Aaron	Shareholder	Clerical	0.56%	See Attached	3.68	9.20%	Alloc. Salary	7,713	21-07	6	
7	Fred Aaron	Shareholder	Administrative	13.10%	See Attached	9.00	20.00%	Sal/Alloc. Sal	43,100	17-01/17-07	7	
8	Daniel Aaron	Relative	Administrative	0%	See Attached	11.28	28.19%	Alloc. Salary	18,055	17-07	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 130,505		13	

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

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	407,367	13	\$ 10,618	\$ 35,606	\$ 928	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	407,367	13	78,675	35,606	6,877	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	407,367	13	2,289	35,606	200	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,367	13	30,482	35,606	2,664	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	407,367	13	27,992	35,606	2,447	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,367	13	914,524	670,657	79,934	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,367	13	26,915	35,606	2,353	7
8	25	AUTO EXP.	PATIENT DAYS	407,367	13	22,263	35,606	1,946	8
9	26	INSURANCE	PATIENT DAYS	407,367	13	31,386	35,606	2,743	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	407,367	13	138,888	35,606	12,140	10
11	30	DEPRECIATION	PATIENT DAYS	407,367	13	25,822	35,606	2,257	11
12	32	INTEREST	PATIENT DAYS	407,367	13	21,500	35,606	1,879	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,367	13	40,240	35,606	3,517	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	407,367	13		35,606		14
15	35	AUTO RENTAL	PATIENT DAYS	407,367	13	109,345	35,606	9,557	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	407,367	13	770	35,606	67	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,481,709	\$ 705,825	\$ 129,509	25

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	9	59,373	59,373	4.19	6,224	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.68	18,400	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	4.19	20,965	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	5,500	5,500	9.00	1,100	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	64,041	64,041	11.28	18,055	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	133,279	133,279	-		6
7	17	ADMIN. CMP. - B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	200,000	200,000	-		7
8	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	15,271	15,271	-		8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	75,266	75,266	-		9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	147,459	5.24	15,454	10
11	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		11
12	17	ADMIN. CMP. - V. DAVIS (NON-O	WGHTD. AVG. HOURS	40	10	114,789	114,789	3.68	10,561	12
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	68,028	68,028	-		13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	130,998	130,998	4.72	13,740	14
15	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	40	10	195,028	195,028	3.68	17,944	15
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	83,832	83,832	3.68	7,713	16
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	64,541	64,541	0.26	594	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,769,405	\$ 1,769,407		\$ 130,750	25

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	9	6,168	4.19	647	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,514	3.68	1,059	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,139	4.19	1,482	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,260	9.00	7,852	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	5,167	11.28	1,457	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	35,129	-		6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,844	-		7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	1,340	-		8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,046	-		9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,501	5.24	1,101	10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,078	-		11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	32,072	3.68	2,951	12
13	27	EMP. BEN.-A. CASSATA (NON-OW	WGHTD. AVG. HOURS	40	1	5,480	-		13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	43,223	4.72	4,534	14
15	27	EMP. BEN.- CFO (NON-OWNER)	WGHTD. AVG. HOURS	40	10	24,786	3.68	2,280	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	17,251	3.68	1,587	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	37,525	0.26	345	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 322,523	\$	\$ 25,295	25

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number

Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	HUD		X	Mortgage				\$	\$ 8,132,172		\$ 328,086	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	MB Financial Bank		X	Line of Credit					500,000		36,493	6							
7												7							
8												8							
9	TOTAL Facility Related							\$	\$ 8,632,172		\$ 364,579	9							
B. Non-Facility Related*																			
10	Interest Income		X								(56,932)	10							
11	Interest Income - Bldg. Co		X								(952)	11							
12	Allocated - Dynamic HC	X									1,879	12							
13												13							
14	TOTAL Non-Facility Related							\$	\$		\$ (56,005)	14							
15	TOTALS (line 9+line14)							\$	\$ 8,632,172		\$ 308,575	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 57,954 Line # 36

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

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

Facility Name & ID Number

Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 report.		\$	<u>42,000</u>	1		
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>45,092</u>	2		
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>3,092</u>	3		
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>42,000</u>	4		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>45,092</u>	7		
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	<u>39,913</u>	8	FOR BHF USE ONLY		
	2011	<u>40,746</u>	9			
	2012	<u>41,732</u>	10			
	2013	<u>40,582</u>	11			
	2014	<u>41,575</u>	12			
2015 Accrual = \$41,575 x 1.01 = \$42,000 (Rounded)				13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
Allocated - Dynamic HC Consultants - \$3,517				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	116	1998	1975	\$ 2,544,733	\$ 132,031	39	\$ 65,250	\$ (66,781)	\$ 1,108,969	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1990	21,410		20			21,410	9
10	Various		1991	9,997		20			9,918	10
11	Various		1992	4,279		20			4,275	11
12	Various		1993	26,868		20			26,868	12
13	Various		1994	8,312		20	234	234	8,310	13
14	Various		1995	3,234		20	235	235	3,234	14
15	Various		1996	17,411		20	1,741	1,741	16,686	15
16	Various		1997	68,499		20	6,850	6,850	61,764	16
17	Various		1998	31,645		20	3,165	3,165	28,014	17
18	Various		1999	147,088		20	14,593	14,593	120,220	18
19	Various		2000	149,982		20	14,998	14,998	116,615	19
20	Various		2001	139,226		20	13,923	13,923	100,508	20
21	Various		2002	52,106		20	317	317	51,088	21
22	Various		2003	79,602		20			79,602	22
23	Various		2004	54,194		20	1,076	1,076	54,194	23
24	Various		2005	41,185		20	2,800	2,800	41,185	24
25	Various		2006	24,334		20	4,334	4,334	23,602	25
26	Various		2007	36,779		20	6,559	6,559	30,549	26
27	Various		2008	74,672		20	12,470	12,470	64,705	27
28	Various		2009	29,315		20	2,543	2,543	16,550	28
29	Various		2010	48,685		20	4,053	4,053	11,051	29
30	Various		2011	36,523		20	5,836	5,836	13,400	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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		415,722			20,786	20,786	20,786	67
68		38,773	994		1,108	114	24,741	68
69			185,827			(185,827)		69
70		\$ 4,104,574	\$ 318,852		\$ 182,870	\$ (135,982)	\$ 2,058,245	70

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,104,574	\$ 318,852		\$ 182,870	\$ (135,982)	\$ 2,058,245	1
2	Kitchen And Showers-2Nd Fl-Wall/Support Brace/Locks/Painting	2012	2,569		20	1,028	1,028	1,884	2
3	2Nd Fl Nurse Stat./Bathrooms-Sinks/Shelving/Support/Counter2N	2012	7,329		20	2,931	2,931	5,252	3
4	Dining Room/Lobby/Computer Room-WallcoveringsDining Room	2012	3,526		20	1,411	1,411	2,527	4
5	2Nd Floor Bathroom Vanity, Sinks, Window, Faucet	2012	9,073		20	465	465	785	5
6	2Nd Floor- Wallcovering, Painting, Supports	2012	2,775		20	1,110	1,110	1,943	6
7	Handrail And Crash Rail- 2Nd Floor Hallway	2012	16,806		20	6,722	6,722	11,764	7
8	Floors/Wallcovering-2Nd Fl Nurse St/Dining/Lobby/Corridors	2012	31,447		20	12,579	12,579	22,013	8
9	2Nd Floor Res Rooms/Corridors- Ceiling Tiles/Wallcoverings/Flo	2012	5,843		20	2,337	2,337	3,993	9
10	2Nd Floor Res Rooms/Corridors- Window Treatments	2012	4,178		20	1,671	1,671	2,855	10
11	Signage - In Front Of Doors	2012	3,029		20	1,212	1,212	2,070	11
12	Lighting In Dining Room/Library/Nurses Station/Corridor	2012	10,222		20	4,089	4,089	6,985	12
13	Carpeting/Floor Coverings:2Nd Fl. Rooms/Corridors/Stations	2012	20,150		20	8,060	8,060	13,433	13
14	New Vanity/Countertops/Sinks In Kitchen And Bathroom	2012	4,946		20	254	254	417	14
15	2Nd Fl.Bathrms/Boiler-Laundry Rm- Plumbing/Vanity/Flooring	2012	4,982		20	1,993	1,993	3,238	15
16	2Nd Floor Bathroom/Kitchen- Cabinets/Walls/Flooring	2012	10,383		20	4,153	4,153	6,749	16
17	Elevator Work	2013	2,560		20	256	256	373	17
18	Installed New Hydraulic Oil In Elevators	2013	8,155		20	816	816	1,189	18
19	Resident Bathroom Countertops - 2Nd Floor	2013	4,596		20	236	236	329	19
20	Bathroom Trim Molding, Mirror, Grout, Light Fixtures - 2Nd Flo	2013	4,473		20	1,789	1,789	2,534	20
21	Smoke Alarm, Safety Guard, Bathroom Lock, Plumbing - 2Nd Flo	2013	3,324		20	1,330	1,330	1,828	21
22	Light Fixtures In Resident Rooms - 2Nd Floor	2013	7,699		20	3,080	3,080	4,235	22
23	New Grease Trap In Kitchen	2013	6,073		20	311	311	409	23
24	Build Out Kitchen And Install Grease Traps	2013	11,804		20	605	605	744	24
25	Woodframes And Boards For Flooring - 2Nd Floor	2013	7,746		20	397	397	488	25
26	Light Fixtures, Curtains, Window Treatments, Floor - 2Nd Floor	2013	67,805		20	27,122	27,122	33,902	26
27	Install Carpet Covering - 2Nd Floor	2013	8,208		20	3,283	3,283	3,967	27
28	Fixture & Lighting - 2Nd Floor	2013	4,972		20	1,989	1,989	2,403	28
29	Outlets For 1St Floor	2013	4,072		20	1,629	1,629	1,832	29
30	Security Equip	2013	2,895		20	1,158	1,158	1,303	30
31	Security Equip	2013	3,395		20	1,358	1,358	1,471	31
32	Molding, Towel Bars For First Floor Bathrooms	2013	10,408		20	4,163	4,163	4,337	32
33	Rewired Indicating Circuits & Installed New Fire Alarm System D	2014	4,950		20	1,179	1,179	1,179	33
34	TOTAL (lines 1 thru 33)		\$ 4,404,966	\$ 318,852		\$ 283,585	\$ (35,267)	\$ 2,206,678	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,404,966	\$ 318,852		\$ 283,585	\$ (35,267)	\$ 2,206,678	1
2	1St Floor Bathroom Piping, Tile Drywall, Outlets, Paint, Lights, T	2014	6,997		20	583	583	583	2
3	1St Floor Countertops & Shelving	2014	19,084		20	1,590	1,590	1,590	3
4	1St Floor Flooring	2014	11,689		20	974	974	974	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,442,736	\$ 318,852		\$ 286,732	\$ (32,120)	\$ 2,209,825	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,442,736	\$ 318,852		\$ 286,732	\$ (32,120)	\$ 2,209,825	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		\$ 4,442,736	\$ 318,852		\$ 286,732	\$ (32,120)	\$ 2,209,825	34

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,442,736	\$ 318,852		\$ 286,732	\$ (32,120)	\$ 2,209,825	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		\$ 4,442,736	\$ 318,852		\$ 286,732	\$ (32,120)	\$ 2,209,825	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	First Floor Bathrooms Remodeling - Tile, Fixtures, Counter Tops	2015	27,461		20	1,373	1,373	1,373	9
10	First Floor Carpeting	2015	11,689		20	584	584	584	10
11	First Floor Corridor - Wall Coverings, Ceiling Tile, Light Fixtures	2015	101,128		20	5,056	5,056	5,056	11
12	Front Entrance - Windows, Roof, Sprinkler, and Gutters	2015	108,854		20	5,443	5,443	5,443	12
13	Installed Wall Coverings in Offices	2015	19,776		20	989	989	989	13
14	Poured Sidewalk	2015	7,052		20	353	353	353	14
15	Construction of Seatwall and Pillars with lights, and Patio	2015	27,135		20	1,357	1,357	1,357	15
16	Landscaping	2015	3,874		20	194	194	194	16
17	New Heating Unit and Duct Work	2015	7,384		20	369	369	369	17
18	Installed Window Treatments	2015	27,859		20	1,393	1,393	1,393	18
19	Custom Nursing Stations	2015	34,379		20	1,719	1,719	1,719	19
20	Wall Covering in Office and Corridor and 30 Corner Guards	2015	29,306		20	1,465	1,465	1,465	20
21	Signage for Corridor and Reception Area	2015	9,825		20	491	491	491	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)		\$ 415,722	\$		\$ 20,786	\$ 20,786	\$ 20,786	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 415,722	\$		\$ 20,786	\$ 20,786	\$ 20,786
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 415,722	\$		\$ 20,786	\$ 20,786	\$ 20,786

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Dynamic HC Consultants	1993	38,773	994	35	1,108	114	24,741	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	TOTAL (lines 1 thru 33)		\$ 38,773	\$ 994		\$ 1,108	\$ 114	\$ 24,741	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 38,773	\$ 994		\$ 1,108	\$ 114	\$ 24,741	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)	\$ 38,773	\$ 994		\$ 1,108	\$ 114	\$ 24,741	34

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 662,302	\$ 935	\$ 165,080	\$ 164,145	10	\$ 483,349	71
72	Current Year Purchases	37,781		4,088	4,088	10	4,088	72
73	Fully Depreciated Assets	938,199				10	938,113	73
74								74
75	TOTALS	\$ 1,638,282	\$ 935	\$ 169,167	\$ 168,232		\$ 1,425,550	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2004	\$ 44,500	\$	\$	\$	5	\$ 44,500	76
77		Used Van	2005	16,080				5	16,080	77
78		Allocated - Dynamic HC Consulta	2005	20,601	328	3,253	2,925	5	16,259	78
79										79
80	TOTALS			\$ 81,181	\$ 328	\$ 3,253	\$ 2,925		\$ 76,839	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)	\$ 6,490,058	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 320,115	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 459,152	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 139,037	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,712,214	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	Various Improvements	\$ 49,809	92
93			93
94			94
95		\$ 49,809	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.

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: \$ 1,809

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	Facility	2015 Ford Starcraft	\$ 733.00	\$ 8,796	17
18	Allocated - Dynamic HC Consultants			9,557	18
19					19
20					20
21	TOTAL		\$ 733.00	\$ 18,353	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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

* 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost													
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 235,577		\$	\$			\$	235,577					1	
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	27,470												27,470	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 01	hrs	198,541												198,541	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							187,537						187,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify): <u>See Supplemental</u>									17,505						17,505	13
14	TOTAL			\$ 461,588		\$	\$			205,042		\$			\$ 666,630	14	

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 50,877	\$ 289,523	1
2	Cash-Patient Deposits	39,108	39,108	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,154,631	1,154,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,587	107,582	6
7	Other Prepaid Expenses	5,136	5,136	7
8	Accounts Receivable (owners or related parties)		19,001	8
9	Other(specify):	14,913	444,234	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,353,252	\$ 2,059,215	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	1,503,484	1,821,978	15
16	Equipment, at Historical Cost	1,328,691	1,863,868	16
17	Accumulated Depreciation (book methods)	(2,217,559)	(3,802,303)	17
18	Deferred Charges		157,151	18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(15,167)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,066,214	1,066,214	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,680,830	\$ 3,970,333	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,034,082	\$ 6,029,548	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 475,479	\$ 491,458	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,108	39,108	28
29	Short-Term Notes Payable	500,000	657,759	29
30	Accrued Salaries Payable	279,476	279,476	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,575	5,575	31
32	Accrued Real Estate Taxes(Sch.IX-B)		42,000	32
33	Accrued Interest Payable	2,153	29,260	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,360	13,360	35
Other Current Liabilities(specify):				
36	See Attached Schedule	128,000	128,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,443,151	\$ 1,685,996	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,974,413	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,974,413	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,443,151	\$ 9,660,409	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,590,931	\$ (3,630,861)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,034,082	\$ 6,029,548	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,079,552	1
2	Restatements (describe):		2
3	Equity Restatement	50,743	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,130,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,164)	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	(255,200)	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)	\$ (539,364)	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)	\$ 1,590,931	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning: 01/01/15

Ending:

12/31/15

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,358,375	1
2	Discounts and Allowances for all Levels	(1,803,003)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,555,372	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,746,470	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,746,470	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	262,128	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,749	19
20	Radiology and X-Ray	7,144	20
21	Other Medical Services	10,353	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 319,374	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	56,932	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56,932	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	70,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 70,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,748,148	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,081,715	31
32	Health Care	2,554,783	32
33	General Administration	2,137,070	33
B. Capital Expense			
34	Ownership	1,315,745	34
C. Ancillary Expense			
35	Special Cost Centers	696,430	35
36	Provider Participation Fee	246,569	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,032,312	40
41	Income before Income Taxes (line 30 minus line 40)**	(284,164)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (284,164)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,180,750	44
45	Private Pay - Net Inpatient Revenue	1,308,396	45
46	Medicare - Net Inpatient Revenue	957,493	46
47	Other-(specify) <u>Hospice</u>	108,733	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,555,372	49

* 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.

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

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,523	1,770	\$ 82,101	\$ 46.38	1
2	Assistant Director of Nursing	2,527	2,743	133,696	48.74	2
3	Registered Nurses	17,744	18,934	542,842	28.67	3
4	Licensed Practical Nurses	16,578	17,550	497,225	28.33	4
5	CNAs & Orderlies	64,359	69,162	804,632	11.63	5
6	CNA Trainees					6
7	Licensed Therapist	10,118	10,917	461,588	42.28	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,151	56,818	26.41	9
10	Activity Assistants	11,838	12,862	130,867	10.17	10
11	Social Service Workers	2,877	3,037	60,772	20.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,693	2,895	62,241	21.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,236	2,548	141,151	55.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,855	5,126	90,049	17.57	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	1,718	1,879	37,169	19.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,466	3,604	59,400	16.48	33
34	TOTAL (lines 1 - 33)	144,452	155,178	\$ 3,160,551 *	\$ 20.37	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			35	
36	Medical Director	120	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	7,488	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	32	1,664	11-03	44
45	Social Service Consultant	136	8,840	12-03	45
46	Other(specify)				46
47	Outside Dietary Services		397,596	01-03	47
48					48
49	TOTAL (lines 35 - 48)	480	\$ 427,588		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Pamela Ingold	Administrator	0	\$ 99,151	Workers' Compensation Insurance	\$ 66,954	IDPH License Fee	\$	
Fred Aaron	Administrative	13.10	42,000	Unemployment Compensation Insurance	43,270	Advertising: Employee Recruitment	53,442	
				FICA Taxes	238,778	Health Care Worker Background Check		
				Employee Health Insurance	182,523	(Indicate # of checks performed 301)	3,016	
				Employee Meals	13,414	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	15,543	
				Other Employee Benefits	15,447	Licenses and Permits	6,663	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated - Dynamic HC Consultants	2,447	
(List each licensed administrator separately.)			\$ 141,151			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 560,385	TOTAL (agree to Sch. V,	\$ 81,111	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Health Data Systems	Clinical / E.H.R.		\$ 5,923			\$	Out-of-State Travel	\$
Dynamic HC Consultants	Bookkeeping / Home Office		465,000					
Imagine Landscape Design	Landscaping Consulting		677					
Personnel Planners	Unemployment Consultant		1,813				In-State Travel	
Dynamic HC Consultants	Data Processing		12,414					
United Analytical Services	Asbestos Inspection Services		535					
FRR / Marcum	Accounting		32,164				Seminar Expense	6,875
eHealth Data Solutions	Risk Management Software		4,093				Allocated - Dynamic HC Consultants	2,353
NTT Data LTC Solutions	Data Processing		18,992					
Casamba	EMR for Therapy		3,600				Entertainment Expense	()
National Data Corporation	Data Processing		3,415				(agree to Sch. V,	
See Supplemental Schedule			39,507				line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 9,228
(For legal fee disclosure, see page 39 of instructions)			\$ 588,133					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Willow Crest Nsg. Pavilion

0036533

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 \$22,029
- (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. \$ 150 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 246,569
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. \$ 13,414 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% LN 14
- 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.