

Facility Name & ID Number Willow House

0041335 Report Period Beginning: 10/01/14 Ending: 09/30/15

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,174			5,174	13
14	TOTALS	5,174			5,174	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.60%

D. How many bed-hold days during this year were paid by the Department? 180 (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)

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 05/15/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/1995 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 09/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	41,042		1,322	42,364		42,364		42,364		
2	Food Purchase		29,363		29,363		29,363		29,363		
3	Housekeeping	29,849	5,401		35,250		35,250	66	35,316		
4	Laundry	26,118	1,137		27,255		27,255		27,255		
5	Heat and Other Utilities			22,464	22,464		22,464	1,980	24,444		
6	Maintenance			15,058	15,058		15,058	10,564	25,622		
7	Other (specify):*										
8	TOTAL General Services	97,009	35,901	38,844	171,754		171,754	12,610	184,364		
	B. Health Care and Programs										
9	Medical Director		8,765	6,048	14,813		14,813	4	14,817		
10	Nursing and Medical Records	141,666		20,581	162,247		162,247	17,419	179,666		
10a	Therapy										
11	Activities	14,924	10,944		25,868		25,868		25,868		
12	Social Services							13,295	13,295		
13	CNA Training	11,446			11,446		11,446		11,446		
14	Program Transportation			2,860	2,860		2,860	2,148	5,008		
15	Other (specify):*										
16	TOTAL Health Care and Programs	168,036	19,709	29,489	217,234		217,234	32,866	250,100		
	C. General Administration										
17	Administrative	45,055		172,793	217,848		217,848	(107,799)	110,049		
18	Directors Fees							476	476		
19	Professional Services			4,808	4,808		4,808	2,635	7,443		
20	Dues, Fees, Subscriptions & Promotions			1,563	1,563		1,563	188	1,751		
21	Clerical & General Office Expenses	14,924	829	4,486	20,239		20,239	15,949	36,188		
22	Employee Benefits & Payroll Taxes			58,530	58,530		58,530	21,592	80,122		
23	Inservice Training & Education			333	333		333		333		
24	Travel and Seminar							905	905		
25	Other Admin. Staff Transportation			1,212	1,212		1,212	3,396	4,608		
26	Insurance-Prop.Liab.Malpractice			7,430	7,430		7,430	3,219	10,649		
27	Other (specify):*										
28	TOTAL General Administration	59,979	829	251,155	311,963		311,963	(59,439)	252,524		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	325,024	56,439	319,488	700,951		700,951	(13,963)	686,988		

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			17,397	17,397		17,397	13,907	31,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			323	323		323	3,823	4,146			32
33	Real Estate Taxes			29,574	29,574		29,574	2,832	32,406			33
34	Rent-Facility & Grounds			92,400	92,400		92,400		92,400			34
35	Rent-Equipment & Vehicles							256	256			35
36	Other (specify):*											36
37	TOTAL Ownership			139,694	139,694		139,694	20,818	160,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,997	67,997		67,997		67,997			42
43	Other (specify):* IL Repl Tax			3,660	3,660		3,660	(3,660)				43
44	TOTAL Special Cost Centers			71,657	71,657		71,657	(3,660)	67,997			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	325,024	56,439	530,839	912,302		912,302	3,195	915,497			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning: 10/01/14

Ending: 09/30/15

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				9
10	Interest and Other Investment Income	(97)	32-3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,660)	43-3		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,757)		\$	30

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule Sch. VIII	6,952		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,952		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 3,195		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

SEE ACCOUNTANTS' COMPILATION REPORT

Willow House

ID# 0041335

Report Period Beginning: 10/01/14

Ending: 09/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14

Ending:

09/30/15

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	8											
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	16											
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	28											
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	29											

STATE OF ILLINOIS

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14 Ending:

Summary B

09/30/15

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	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 Schedule VII C		See Attached Schedule		Health Services Consu	Champaign, IL	Consulting
				Cobblestone Rehabilit	Champaign, IL	Therapy
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate
				The Residential Develo	Champaign, IL	Long-Term Care
				Developmental Found	Champaign, IL	Long-Term Care

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Schedule VIII	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Alan Ryle	Chairman	0.50	All related party wages are allocated from			Administrative	\$ 934	17-7	1
2	Lynn Ryle	Director	0.50	HSC. See attached allocation spreadsheet			Administrative	934	17-7	2
3				and explanation. These individuals receive						3
4	Alan Ryle	Chairman	0.50	no compensation from entities other			Director's Fees	238	18-7	4
5	Lynn Ryle	Director	0.50	than HSC.			Director's Fees	238	18-7	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$ 2,344		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14

Ending: 09/30/15

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

Name of Related Organization Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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

1	2	3	4	5	6	7	8	9			
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6			
1	10	Nursing	Reverse actual amounts paid and accrued to HSC for services		\$	\$		(10,027)	1		
2	17	Administrative	provided in order to allocate HSC's actual expenses					(172,793)	2		
3									3		
4	3	Housekeeping	Housekeeping	323	32	1,329	16	66	4		
5	5	Heat & Utilities	Heat & Utilities	323	32	39,966	16	1,980	5		
6	6	Maintenance	Maintenance	323	32	201,437	16	134,957	6		
7	9	Medical Director	Medical Director	323	32	73	16	4	7		
8	10	Nursing	Nursing	323	32	339,641	16	339,641	8		
9	12	Social Services	Social Services	323	32	268,390	16	268,390	9		
10	14	Program Transportation	Program Transportation	323	32	43,367	16	2,148	10		
11	17	Administrative	Administrative	323	32	954,649	16	893,401	11		
12	18	Director's Fees	Director's Fees	323	32	9,600	16	476	12		
13	19	Professional Fees	Professional Fees	323	32	53,193	16	2,635	13		
14	20	Dues & Subscriptions	Dues & Subscriptions	323	32	3,789	16	188	14		
15	21	Clerical	Clerical	323	32	321,974	16	250,951	15		
16	22	P/R Taxes & Benefits	P/R Taxes & Benefits	323	32	536,759	16	21,592	16		
17	24	Travel & Seminar	Travel & Seminar	323	32	18,262	16	905	17		
18	25	Administrative & Transportation	Administrative & Transportation	323	32	68,566	16	3,396	18		
19	26	Insurance	Insurance	323	32	64,974	16	3,219	19		
20	30	Depreciation	Depreciation	323	32	280,754	16	13,907	20		
21	32	Interest	Interest	323	32	79,127	16	3,920	21		
22	33	Real Estate Tax	Real Estate Tax	323	32	57,170	16	2,832	22		
23	35	Equipment Lease	Equipment Lease	323	32	5,174	16	256	23		
24	N/A	Salaries & Wages	Salaries & Wages			928,005	16	928,005	24		
25	TOTALS				\$	4,276,199	\$	2,815,345	\$	6,952	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Willow House

0041335

Report Period Beginning:

10/01/14

Ending:

09/30/15

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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						
	Working Capital																	
6	Busey Bank		X	Working Capital	N/A	3/7/12	N/A		09/30/14	4.5000	323	6						
7	Schedule VIII Allocation		X								3,920	7						
8	Schedule VI Adjustment		X								(97)	8						
9	TOTAL Facility Related						\$	\$			\$ 4,146	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$	\$			\$ 4,146	15						

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

* 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>25,902</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>30,543</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>4,641</u>		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>24,933</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>29,574</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>24,749</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>26,955</u>	9																
	2012	<u>30,086</u>	10																
	2013	<u>28,498</u>	11																
	2014	<u>30,543</u>	12																
<u>Real estate tax accrual is based on estimated 2015 tax.</u>																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Willow House

0041335 Report Period Beginning:

10/01/14 Ending:

09/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,200 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Concrete Slab		7/29/2004	1,450		7			1,450	9
10	Road Repair		2/16/2005	1,263		7			1,263	10
11	Dining & Kitchen Flooring		12/5/2005	5,559		5			5,559	11
12	Tile/Adhesive		2/10/2006	2,952		5			2,952	12
13	Cabinets & Knobs		6/29/2006	532		7			532	13
14	Wood Flooring		7/25/2006	3,897		5			3,897	14
15	Tile Flooring		8/4/2006	4,766		5			4,766	15
16	Control Panel-Alarm		10/6/2006	1,153	42	27.5	42		378	16
17	Remodel Bathroom		1/9/2007	572	21	27.5	21		184	17
18	Furnace		11/20/2007	2,900	105	27.5	105		825	18
19	Bathroom Tile		12/14/2009	2,808	562	5	562		3,370	19
20	New Roof		10/18/2010	15,300	556	27.5	556		2,734	20
21	Tile Flooring		11/29/2010	7,707	1,541	5	1,541		7,456	21
22	Kitchen Cabinets/Counter Tops		12/1/2010	3,618	132	27.5	132		638	22
23	Dining Room Flooring		2/10/2011	701	140	5	140		653	23
24	Counter Tops		3/8/2013	583	83	7	83		215	24
25	Sprinkler Head Replacement		1/20/2014	3,677	134	27.5	134		223	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14

Ending:

09/30/15

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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			59,438	3,316		3,316		37,095

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 28,138	\$ 1,816	\$ 1,816	\$	5/7/27.5	\$ 10,753	71
72	Current Year Purchases					5/7/27.5		72
73	Fully Depreciated Assets	6,861				5/7	6,861	73
74								74
75	TOTALS	\$ 34,999	\$ 1,816	\$ 1,816	\$		\$ 17,614	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	Wheelchair Tiedowns	Sure Lok	2003	\$ 1,118	\$	\$	\$	5	\$ 1,118	76
77	Patient Transportation	2003 Dodge 3500V Hi Top	2004	39,949				5	39,949	77
78	Patient Transportation	2011 Ford E250 High Top Van	2010	43,747	8,749	8,749		5	42,287	78
79	Admin. Transportation	2010 Hyundai Elantra	2010	17,578	3,516	3,516		5	16,994	79
80	TOTALS			\$ 102,392	\$ 12,265	\$ 12,265	\$		\$ 100,348	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)	\$ 196,829	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,397	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,397	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 155,057	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning: 10/01/14

Ending: 09/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

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:	1995	16		\$ 92,400			3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 92,400			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. Month to \$ _____

13. month lease \$ _____

14. _____ \$ _____

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: N/A *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House # 0041335 Report Period Beginning: 10/01/14 Ending: 09/30/15
 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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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)	136	3,679		3,815
4	Clinical Wages (b)	273	7,358		7,631
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 409	\$ 11,037	\$	\$ 11,446
10	SUM OF line 9, col. 1 and 2 (e)	\$ 11,446			

- (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.

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>9</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	10

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$		\$		\$								14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House# 0041335Report Period Beginning: 10/01/14

Ending:

09/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/15

(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	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 5,000)	171,981		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 172,131	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	59,438		15
16	Equipment, at Historical Cost	137,391		16
17	Accumulated Depreciation (book methods)	(155,057)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 41,772	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 213,903	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,024		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,933		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 42,957	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 42,957	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 170,946	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 213,903	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 196,148	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 196,148	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	165,777	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 165,777	17
B. Transfers (Itemize):			
18	Transfers (to) from Specialized Developments, LTD	(190,979)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (190,979)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 170,946	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,070,733	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,070,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	97	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 97	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Sale of Equipment	7,249	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,249	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,078,079	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	171,754	31
32	Health Care	217,234	32
33	General Administration	311,963	33
B. Capital Expense			
34	Ownership	139,694	34
C. Ancillary Expense			
35	Special Cost Centers	3,660	35
36	Provider Participation Fee	67,997	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 912,302	40
41	Income before Income Taxes (line 30 minus line 40)**	165,777	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 165,777	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14

Ending:

09/30/15

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	1,120	1,120	11,446	10.22
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	1,460	1,460	14,924	10.22
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,095	1,095	11,193	10.22
15	Cook Helpers/Assistants	2,920	2,920	29,849	10.22
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	2,920	2,920	29,849	10.22
19	Laundry	2,555	2,555	26,118	10.22
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	2,348	2,571	45,055	17.52
23	Office Manager				23
24	Clerical	1,460	1,460	14,924	10.22
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,565	1,714	30,037	17.52
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	8,409	10,920	111,629	10.22
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	25,852	28,735	\$ 325,024 *	\$ 11.31

* 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	\$ 1,322	1-3	35
36	Medical Director	6,048	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	9,661	10-3	38
39	Pharmacist Consultant	360	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	991	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,000	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) COTA Consultant	3,800	10-3	46
47	Dentist Consultant	274	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 25,456		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning: 10/01/14

Ending: 09/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Krystal Hawkins	Other Admin	0	\$ 24,031	Workers' Compensation Insurance	\$ 12,392	IDPH License Fee	\$	
Kandice Henry	Other Admin	0	20,058	Unemployment Compensation Insurance	2,496	Advertising: Employee Recruitment	9	
Kiimyhatta Pankey	Other Admin	0	966	FICA Taxes	24,864	Health Care Worker Background Check		
				Employee Health Insurance	11,328	(Indicate # of checks performed)	117	
				Employee Meals	6,923	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,437	
				Other	527	Schedule VIII Allocation	188	
				Schedule VIII Allocation	21,592			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 45,055					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management & Support Staff Fees			\$ 172,793	None		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 172,793				In-State Travel	
(Attach a copy of any management service agreement)							Schedule VII Allocation	905
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type	Amount						
Martin, Hood, Friese & Assoc	Accounting	\$ 2,751						
Thomas, Mamer, & Haughey	Legal	100						
Various	Other Professional Svcs	1,957						
TOTAL (agree to Schedule V, line 19, column 3)				\$			Entertainment Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 4,808				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 905

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow House

0041335

Report Period Beginning:

10/01/14

Ending:

09/30/15

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. IARF - \$1,296.79
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,997
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? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? None
- (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. \$ 6,923 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? Attached
 - 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? None
 - 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? None
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.