

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0020792

Facility Name: WILLOWS HEALTH CENTER

Address: 4054 ALBRIGHT LANE ROCKFORD 61103
Number City Zip Code

County: WINNEBAGO

Telephone Number: 815-654-2530 Fax # 815-654-2545

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1972

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: MARK TICKNOR Telephone Number: 815-316-1518
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2015 to 06/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) MARK TICKNOR
(Title) TREASURER

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOWS HEALTH CENTER

0020792 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	<u>91</u>	Skilled (SNF)	<u>91</u>	<u>33,306</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>36</u>	Sheltered Care (SC)	<u>36</u>	<u>13,176</u>	5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,482	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,892</u>	<u>15,266</u>	<u>3,714</u>	<u>23,872</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>11,816</u>		<u>11,816</u>	12
13	DD 16 OR LESS					13
14	TOTALS	4,892	27,082	3,714	35,688	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.78%

D. How many bed-hold days during this year were paid by the Department? 0 (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)

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 07/01/1972

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 20 and days of care provided 2,822

Medicare Intermediary NHIC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2016 Fiscal Year: 06/30/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **WILLOWS HEALTH CENTER** # **0020792** Report Period Beginning: **07/01/2015** Ending: **06/30/2016**
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	848,100	121,691		969,791		969,791		969,791			1
2	Food Purchase		478,800		478,800		478,800		478,800			2
3	Housekeeping	147,124	21,515		168,639		168,639		168,639			3
4	Laundry	38,256	160,074		198,330		198,330		198,330			4
5	Heat and Other Utilities			156,213	156,213		156,213		156,213			5
6	Maintenance	137,136	77,258	197,011	411,405		411,405		411,405			6
7	Other (specify):* Hr/Marketing	127,157	2,304	34,771	164,232		164,232		164,232			7
8	TOTAL General Services	1,297,773	861,642	387,995	2,547,410		2,547,410		2,547,410			8
	B. Health Care and Programs											
9	Medical Director	34,808			34,808		34,808		34,808			9
10	Nursing and Medical Records	4,204,506	336,131	745,094	5,285,731		5,285,731		5,285,731			10
10a	Therapy											10a
11	Activities											11
12	Social Services	215,130	8,427	19,077	242,634		242,634		242,634			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,454,444	344,558	764,171	5,563,173		5,563,173		5,563,173			16
	C. General Administration											
17	Administrative	283,178			283,178		283,178		283,178			17
18	Directors Fees											18
19	Professional Services			46,324	46,324		46,324		46,324			19
20	Dues, Fees, Subscriptions & Promotions			147,358	147,358		147,358		147,358			20
21	Clerical & General Office Expenses	175,370	19,960	8,854	204,184		204,184		204,184			21
22	Employee Benefits & Payroll Taxes			1,192,069	1,192,069		1,192,069		1,192,069			22
23	Inservice Training & Education											23
24	Travel and Seminar			998	998		998		998			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			149,996	149,996		149,996		149,996			26
27	Other (specify):* Miscellaneous			100,064	100,064		100,064	(27,183)	72,881			27
28	TOTAL General Administration	458,548	19,960	1,645,663	2,124,171		2,124,171	(27,183)	2,096,988			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,210,765	1,226,160	2,797,829	10,234,754		10,234,754	(27,183)	10,207,571			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.

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			401,147	401,147		401,147		401,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			401,147	401,147		401,147		401,147			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			51,103	51,103		51,103		51,103			42
43	Other (specify):* Fund Development			53,328	53,328		53,328	(53,328)				43
44	TOTAL Special Cost Centers			104,431	104,431		104,431	(53,328)	51,103			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,210,765	1,226,160	3,303,407	10,740,332		10,740,332	(80,511)	10,659,821			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	27,183			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				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	53,328			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 80,511		\$	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 Amount	2 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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 80,511		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0020792

Report Period Beginning:07/01/2015

Ending:06/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Telephone, TV & Radio in Resident Rooms	\$ (27,183)	27	1
2	Fund Raising, Advertising and Promotional	(53,328)	43	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
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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	(80,511)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOWS HEALTH CENTER# 0020792

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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):*	(27,183)	0	0	0	0	0	0	0	0	0	0	(27,183)	27
28	TOTAL General Administration	(27,183)	0	0	0	0	0	0	0	0	0	0	(27,183)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(27,183)	0	0	0	0	0	0	0	0	0	0	(27,183)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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):* Fund Developmen	(53,328)	0	0	0	0	0	0	0	0	0	0	(53,328)	43
44	TOTAL Special Cost Centers	(53,328)	0	0	0	0	0	0	0	0	0	0	(53,328)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(80,511)	0	0	0	0	0	0	0	0	0	0	(80,511)	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
Willows Health Center	100			Wesley Willows	Rockford	CCRC

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		Management Fee	\$ 4,200	Wesley Willows	0.00%	\$ 4,200	\$	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			\$ 4,200			\$ 4,200	\$ *	14

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

Facility Name & ID Number

WILLOWS HEALTH CENTER

0020792

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	Doug Lamb	BOD						1
2	Erin Calkins	BOD						2
3	Linda Chang	BOD						3
4	Joe Clinton	BOD						4
5	Mike Davis	BOD						5
6	Lori Diaz	BOD						6
7	Michael Gann	BOD						7
8	Monica Glenney	BOD						8
9	Anne Hammes	BOD						9
10	Mark McClenathan	BOD						10
11	David Schmitt	BOD						11
12	John Shockey	BOD						12
13	Rebecca Epperson	BOD						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

Facility Name & ID Number WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	Doug Lamb	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	\$ 0		1
2	Erin Calkins	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		2
3	Linda Chang	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		3
4	Joe Clinton	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		4
5	Mike Davis	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		5
6	Lori Diaz	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		6
7	Michael Gann	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		7
8	Monica Glenn	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		8
9	Anne Hammes	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		9
10	Mark McClenathan	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		10
11	David Schmitt	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		11
12	John Shockey	BOD Member	Volunteer	0.00	0	N/A	N/A	N/A	0		12
13								TOTAL	\$		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 WILLOWS HEALTH CENTER # 0020792 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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

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	
	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
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	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.)

** 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015 \$	13
		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	WILLOWS HEALTH CENTER	COUNTY	WINNEBAGO
---------------	-----------------------	--------	-----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

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

C. Tax Bills

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,025 **B. General Construction Type:** Exterior Brick Frame Metal 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).

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	Nursing Home	100,000	1974	\$ 14,007	1
2	Nursing Home	30,680	1994	7,729	2
3	TOTALS	130,680		\$ 21,736	3

Facility Name & ID Number WILLOWS HEALTH CENTER

0020792

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	127		1974	1974	\$ 1,138,143	\$ 22,763	50	\$ 22,763		\$ 956,046
5										
6										
7										
8										
	Improvement Type**									
9	VARIOUS		1996		1,027,018	25,675	40	25,675		513,500
10	VARIOUS		1999		276,540		5-15			276,540
11	VARIOUS		2000		25,023		15			25,023
12	VARIOUS		2001		124,603		7-15			124,603
13	VARIOUS		2002		108,978		7-15			108,978
14	VARIOUS		2003		275,984		10-15			275,984
15	VARIOUS		2004		47,559		10-15			47,559
16	VARIOUS		2005		38,401	2,470	10-20	2,470		27,837
17	VARIOUS		2006		352,273	23,485	15	23,485		240,366
18	VARIOUS		2007		17,691	1,180	15	1,180		10,519
19	FLOORING		2008		15,514	1,034	15	1,034		8,395
20	DOOR CLOSERS		2008		46,479	3,099	15	3,099		25,346
21	MIXING VALVE		2008		4,700	313	15	313		2,577
22	LOCKER ROOM RENOVATIONS		2008		9,432	629	15	629		4,822
23	AIR DRYER		2008		3,780	252	15	252		1,946
24	ALARMING		2008		1,176	78	15	78		599
25	FLOORING		2009		24,320	1,621	15	1,621		11,507
26	ROOFING		2009		5,888	393	15	393		2,816
27	ALARMING		2009		3,024	202	15	202		1,435
28	ELEVATOR REBUILD		2009		12,689	846	15	846		6,063
29	GENERATOR UPGRADE		2009		13,139	876	15	876		5,937
30	CALL SYSTEM UPGRADE		2009		5,378	359	15	359		2,483
31	CHILLERS		2009		3,136	209	15	209		1,428
32	KITCHEN HOOD		2009		4,553	304	15	304		2,102
33	ENTRYWAY COLUMNS		2010		4,800	320	15	320		1,920
34	RADIO SYSTEM UPGRADE		2010		3,622	419	15	419		2,400
35	INTAKE AIR FAN		2010		2,267	151	15	151		944
36	FLOORING ROOM F15		2010		2,204	147	15	147		930

*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 WILLOWS HEALTH CENTER

0020792

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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 FLOORING AND CEILING PANELS D109&F102	2010	\$ 2,741	\$ 183	15	\$ 183	\$	\$ 1,037	37
38 UNDERCOUNTER FREEZER UNIT	2010	2,353	157	15	157		888	38
39 FLOORING F5&6, D114,118,120,123,126&127	2010	9,530	635	15	635		3,338	39
40 CHILLED WATER SYSTEM BOILER UPDATE	2011	5,369	358	15	358		1,880	40
41 FLOORING F3,106,108&120, D115&122	2011	6,190	413	15	413		1,953	41
42 CHILLER LANDSCAPING	2011	5,925	395	15	395		1,777	42
43 DOOR REPLACEMENTS, BREEZEWAY, PC ENTR, MAIN	2012	31,246	2,083	15	2,083		8,767	43
44 KEYS AND LOCK RESET	2012	582	39	15	39		169	44
45 FLOORING F1,15&101, D110	2012	5,345	356	15	356		1,462	45
46 WINDOW REPLACEMENT COMPLETE BUILDING	2012	207,920	13,861	15	13,861		56,662	46
47 YORK CONDENSING UNIT	2012	5,986	399	15	399		1,663	47
48 GAS FIRED BOILER AND HOT WATER PUMPS	2013	411,152	16,608	15-40	16,608		58,131	48
49 KITCHEN MAKEUP UNIT	2013	54,703	3,647	15	3,647		12,689	49
50 MEDICARE RM COMPLETE RENOVATION 15 RMS 20 BEDS	2013	346,397	34,639	10	34,639		99,300	50
51 D1-1&2,D2,D3-1&2,D4,D5-1&2,D6,D7-1&2,D8,D9-1&2,D10								51
52 D11,D12,D13,D14,D15 INCLUDING FLOORING, ELECTRICAL								52
53 LIGHTING, PLUMBING, DOORS FIXTURES AND PAINTING								53
54								54
55 HOT WATER SYSTEM UPGRADE	2013	40,314	4,031	10	4,031		11,085	55
56 FLOORING, ROOMS F-19,100,101,106,108,11,F15	2014	5,960	598	10	598		1,026	56
57 FLOORING, ROOMS F-107,D116,102,105,112,101,104,106,								57
58 F-116 AND F 7	2015	20,869	1,757	10	1,757		2,072	58
59 INSTALL POWER DOORS AND RENOVATE ENTRANCE	2015	19,329	1,933	10	1,933		2,094	59
60 REKEYING ALL INTERIOR AND EXTERIOR DOORS	2015	34,542	3,455	10	3,455		4,030	60
61								61
62 FLOORING ROOMS F110,F120,D113,D128,F9,F115,F3	2015	6,425	422	10	422		422	62
63 FLOORING ROOMS D107,F8,F19,F117,F4,F7,F111	2016	6,464	139	10	139		139	63
64 REROOF REHAB AREA	2016	178,404	3,717	10	3,717		3,717	64
65 ACCOUSTICAL CEILINGS ALL ROOMS	2016	14,265	228	10	228		228	65
66 WOOD FLOORING HC CORRIDORS	2016	100,515	838	10	838		838	66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,120,840	\$ 177,716		\$ 177,716	\$	\$ 2,965,972	70

**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	\$ 4,169,925	\$ 194,860	\$ 194,860	\$		\$ 2,614,803	71
72	Current Year Purchases	215,399	28,571	28,571			28,571	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,385,324	\$ 223,431	\$ 223,431	\$		\$ 2,643,374	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	9,527,900
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	401,147
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	401,147
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,609,346

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: _____
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: \$ _____ 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.

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	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 prescrpts							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.

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	\$ (1,071,796)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 235,000)	504,031		3
4	Supply Inventory (priced at COST)	6,358		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)	\$ (561,407)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,736		13
14	Buildings, at Historical Cost	5,120,840		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,385,324		16
17	Accumulated Depreciation (book methods)	(5,609,346)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,083		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,924,637	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,363,230	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,268	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,913		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 528,181	\$	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)	\$ 528,181	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,835,049	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,363,230	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,171,146	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,171,146	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,336,097)	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)	\$ (1,336,097)	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)	\$ 2,835,049	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **WILLOWS HEALTH CENTER**# **0020792**Report Period Beginning: **07/01/2015**Ending: **06/30/2016**

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	\$ 8,911,752	1
2	Discounts and Allowances for all Levels	(1,189,025)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,722,727	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	1,486,091	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,486,091	23
	D. Non-Operating Revenue		
24	Contributions	195,417	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 195,417	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,404,235	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,547,410	31
32	Health Care	5,563,173	32
33	General Administration	2,124,171	33
	B. Capital Expense		
34	Ownership	401,147	34
	C. Ancillary Expense		
35	Special Cost Centers	53,328	35
36	Provider Participation Fee	51,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,740,332	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,336,097)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,336,097)	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? **YES** 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.

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	2,000	2,080	\$ 92,421	\$ 44.43	1
2	Assistant Director of Nursing	8,740	9,090	257,990	28.38	2
3	Registered Nurses	16,832	17,505	528,668	30.20	3
4	Licensed Practical Nurses	33,437	34,775	870,450	25.03	4
5	CNAs & Orderlies	138,750	144,300	2,454,977	17.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,000	12,480	215,130	17.24	11
12	Dietician	2,000	2,080	40,912	19.67	12
13	Food Service Supervisor	6,600	6,864	93,756	13.66	13
14	Head Cook	4,000	4,160	77,278	18.58	14
15	Cook Helpers/Assistants	44,712	46,501	488,445	10.50	15
16	Dishwashers	14,875	15,470	147,709	9.55	16
17	Maintenance Workers	7,934	8,251	137,136	16.62	17
18	Housekeepers	14,186	14,753	147,124	9.97	18
19	Laundry	3,844	3,998	38,256	9.57	19
20	Administrator	1,000	1,040	69,402	66.73	20
21	Assistant Administrator					21
22	Other Administrative	3,000	3,120	213,776	68.52	22
23	Office Manager					23
24	Clerical	10,500	10,920	175,370	16.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	500	500	34,808	69.62	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hr/Marketing</u>	5,816	6,049	127,157	21.02	33
34	TOTAL (lines 1 - 33)	330,726	343,936	\$ 6,210,765 *	\$ 18.06	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	500	34,808	9-1	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	500	\$ 34,808		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,735	\$ 78,099	10-1	50
51	Licensed Practical Nurses	1,041	39,049	10-1	51
52	Certified Nurse Assistants/Aides	12,149	273,345	10-1	52
53	TOTAL (lines 50 - 52)	14,925	\$ 390,493		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Debra Adkins	Administrator	0	\$ 69,402
Brandi McLaughlin	Asst to CEO	0	17,579
Bill Pratt	CEO	0	128,735
Mark Ticknor	CFO	0	67,462
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 283,178
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Wesley Willows	Mgmt Fee	\$	4,200
Nexus/Marco	Copier/Office Equip		2,505
RSM/Polaris	Audit and Consulting		15,000
AOD/Entre	Computer Services		24,619
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 46,324
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	153,623
Unemployment Compensation Insurance			1,900
FICA Taxes			409,504
Employee Health Insurance			518,908
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)* 403b Retirement Plan			108,134
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,192,069
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 100)			
Patient Background Checks	175		
Dues			15,450
LTC Provider Assessment			131,908
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 147,358
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			998
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	998

*** Attach copy of IMRF notifications**

****See instructions.**

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. LSN, UMA, Leading Age
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,000 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,103
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 benefit on Schedule V. \$ 0 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? 0
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? Yes
Firm Name: RSM
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SCHEDULE V LINE 7 EQUALS COST OF HR AND MARKETING DEPTS

SCHEDULE V LINE 24 (TRAVEL AND SEMINAR) DETAILS ATTACHED

TRAVEL	\$	998
MILEAGE REIMBURSEMENT		-
TOTAL	\$	<u>998</u>

SCHEDULE V LINE 27 (MISCELLANEOUS) DETAILS ATTACHED

PAYROLL PROCESSING	\$	19,578
BACKGROUND CHECKS		1,380
BEAUTY SHOP COSTS		50,236
MISCELLANEOUS		1,687
TOTAL	\$	<u>72,881</u>

WILLOWS HEALTH CENTER 0020792

7/01/2015 TO 6/30/2016

SCHEDULE V LINE 43

DEVELOPMENT COSTS INCLUDE COST TO RAISE CONTRIBUTIONS

PAGE 21 , SECTION C LEGAL FEES

NO LEGAL FEES IN 2016

PAGE 24

WILLOWS HEALTH CENTER 0020792

7/01/2015 TO 6/30/2016

SCHEDULE XIII, SECTION A1

NO TRAINING COSTS

AIDES ARE TRAINED AT THE LOCAL COMMUNITY COLLEGE,

ROCK VALLEY COMMUNITY COLLEGE

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