

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: Larry Templin Telephone Number: (630) 361-2868
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 07/01/2024 to 06/30/2025 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)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Willows Health Center # 0020792 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 <u>N/A</u>					
	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>33,215</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>202</u>	Sheltered Care (SC)	<u>202</u>	<u>73,730</u>	5
6		ICF/DD 16 or Less			6
7	<u>293</u>	TOTALS	<u>293</u>	<u>106,945</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	1,659	543			18,533	2,754	2,051	25,540	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC					10,258			10,258	12
13	DD 16 OR LESS									13
14	TOTALS	1,659	543			28,791	2,754	2,051	35,798	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 33.47%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 certified beds.
number of certified beds 91

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025
* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	1,042,936	54,617	4,230	1,101,783		1,101,783		1,101,783			1
2	Food Purchase		523,142		523,142		523,142	(4,159)	518,983			2
3	Housekeeping	350,203	203,591		553,794		553,794		553,794			3
4	Laundry											4
5	Heat and Other Utilities			263,892	263,892		263,892		263,892			5
6	Maintenance	224,400	61,342	168,370	454,112		454,112	25,273	479,385			6
7	Other (specify):*			15,851	15,851		15,851		15,851			7
8	TOTAL General Services	1,617,539	842,692	452,343	2,912,574		2,912,574	21,114	2,933,688			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	4,352,909	324,314	1,783,652	6,460,875		6,460,875		6,460,875			10
10a	Therapy											10a
11	Activities	70,125	5,870	5,555	81,550		81,550		81,550			11
12	Social Services	322,618	1,235	1,182	325,035		325,035		325,035			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,745,652	331,419	1,807,189	6,884,260		6,884,260		6,884,260			16
	C. General Administration											
17	Administrative	259,737		25,857	285,594		285,594	(25,857)	259,737			17
18	Directors Fees											18
19	Professional Services			241,900	241,900		241,900		241,900			19
20	Dues, Fees, Subscriptions & Promotions			11,323	11,323		11,323	(2,200)	9,123			20
21	Clerical & General Office Expenses	475,506	2,485	74,489	552,480		552,480	2,191	554,671			21
22	Employee Benefits & Payroll Taxes			1,865,437	1,865,437		1,865,437		1,865,437			22
23	Inservice Training & Education			18,191	18,191		18,191		18,191			23
24	Travel and Seminar			698	698		698		698			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			168,486	168,486		168,486		168,486			26
27	Other (specify):*											27
28	TOTAL General Administration	735,243	2,485	2,406,381	3,144,109		3,144,109	(25,866)	3,118,243			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,098,434	1,176,596	4,665,913	12,940,943		12,940,943	(4,752)	12,936,191			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION 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	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			473,548	473,548		473,548	(228,166)	245,382			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			18,432	18,432		18,432		18,432			35
36	Other (specify):*											36
37	TOTAL Ownership			491,980	491,980		491,980	(228,166)	263,814			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,445	3,445		3,445		3,445			38
39	Ancillary Service Centers		163,614	646,486	810,100		810,100		810,100			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,394	197,394		197,394		197,394			42
43	Other (specify):* Disallowed Costs	89,516	235	50,392	140,143		140,143	(140,143)				43
44	TOTAL Special Cost Centers	89,516	163,849	897,717	1,151,082		1,151,082	(140,143)	1,010,939			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,187,950	1,340,445	6,055,610	14,584,005		14,584,005	(373,061)	14,210,944			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(4,159)	2		4
5	Telephone, TV & Radio in Resident Rooms	(37,732)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(228,166)	30		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	(2,200)	20		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	(6,895)	43		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 See Page 5A	(68,052)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (347,204)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(25,857)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (25,857)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (373,061)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Willows Health Center

ID# 0020792

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5	Marketing Wages	(89,516)	43	5
6	Property Taxes	(6,000)	43	6
7	Expense Fixed Assets Under \$2,500	2,191	21	7
8	Expense Fixed Assets Under \$2,500	25,273	6	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	(68,052)		49

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	None		Wesley Willows	Rockford	CCRC
				Petersen Meadows	Rockford	Ind/Asst Living
				Willows Cottages	Rockford	Independent Living
				Highview in the		
				Woodlands	Rockton	Assisted Living

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	17	Management Fee	\$ 25,857	Wesley Willows	0.00%	\$	\$ (25,857)	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			\$ 25,857			\$	\$ *	(25,857) 14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8	Note: No board members or entities in which a Board member has ownership conducted business transactions with the nursing home.										8
9											9
10											10
11											11
12											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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Willows Health Center # 0020792 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 X

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	N/A												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. \$ None Line # N/A

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

1. Real Estate Tax accrual used on 2024 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 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
This facility is exempt from paying real estate taxes.					
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willows Health Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0020792

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

	(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.	N/A		\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Steel

Number of Stories

2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Petersen Meadows-99 Apartments-Independent Living/72 Apartments-Assisted Living

Highview in the Woodlands-36 Units-Assisted Living/26 Units-Sheltered Care

Willows Cottages-283 Homes-Independent Living

Willows Suites-112 Homes-Independent Living

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒ 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

K. 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:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	NURSING HOME	100,000	1974	\$ 14,007	1
2	NURSING HOME	30,680	1974	7,729	2
3	TOTALS	130,680		\$ 21,736	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Willows Health Center

#

0020792

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

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	293		1974	1974	\$ 1,138,143	\$	50	\$	\$	\$ 1,138,143
5										
6										
7										
8										
	Improvement Type**									
9	VARIOUS		1996		1,027,018		40			718,900
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		10-20			38,401
17	VARIOUS		2006		352,273		15			352,273
18	VARIOUS		2007		17,691		15			17,691
19	FLOORING		2008		15,514		15			15,514
20	DOOR CLOSERS		2008		46,479		15			46,479
21	MIXING VALVE		2008		4,700		15			4,700
22	LOCKER ROOM RENOVATIONS		2008		9,432		15			9,432
23	AIR DRYER		2008		3,780		15			3,780
24	ALARMING		2008		1,176		15			1,176
25	FLOORING		2009		24,320		15			24,320
26	ROOFING		2009		5,888		15			5,888
27	ALARMING		2009		3,024		15			3,024
28	ELEVATOR REBUILD		2009		12,689		15			12,689
29	GENERATOR UPGRADE		2009		13,139		15	194	194	13,139
30	CALL SYSTEM UPGRADE		2009		5,378		15	23	23	5,378
31	CHILLERS		2009		3,136		15	36	36	3,136
32	KITCHEN HOOD		2009		4,553		15	19	19	4,553
33	ENTRYWAY COLUMNS		2010		4,800		15			4,480
34	RADIO SYSTEM UPGRADE		2010		3,622		15			3,622
35	INTAKE AIR FAN		2010		2,267		15	115	115	2,267
36	FLOORING ROOM F15		2010		2,204		15	98	98	2,204

*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

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOORING AND CEILING PANELS D109&F102	2010	\$ 2,741	\$	15	\$	\$	\$ 2,501	37
38	UNDERCOUNTER FREEZER UNIT	2010	2,353		15			2,144	38
39	FLOORING F5&6, D114,118,120,123,126&127	2010	9,530		15			8,418	39
40	CHILLED WATER SYSTEM BOILER UPDATE	2011	5,369		15			4,744	40
41	FLOORING F3,106,108&120, D115&122	2011	6,190		15			5,257	41
42	CHILLER LANDSCAPING	2011	5,925		15			4,937	42
43	DOOR REPLACEMENTS, BREEZEWAY, PC ENTR, MAIN	2012	31,246		15			25,431	43
44	KEYS AND LOCK RESET	2012	582		15			481	44
45	FLOORING F1,15&101, D110	2012	5,345		15			4,310	45
46	WINDOW REPLACEMENT COMPLETE BUILDING	2012	207,920		15			167,550	46
47	YORK CONDENSING UNIT	2012	5,986		15			4,855	47
48	GAS FIRED BOILER AND HOT WATER PUMPS	2013	411,152		15-40			190,995	48
49	KITCHEN MAKEUP UNIT	2013	54,703		15			41,865	49
50	MEDICARE RM COMPLETE RENOVATION 15 RMS 20 BEDS	2013	346,397		10			346,397	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		10			40,314	55
56	FLOORING, ROOMS F-19,100,101,106,108,11,F15	2014	5,960		10	150	150	5,960	56
57	FLOORING, ROOMS F-107,D116,102,105,112,101,104,106,								57
58	F-116 AND F 7	2015	20,869		10			17,448	58
59	INSTALL POWER DOORS AND RENOVATE ENTRANCE	2015	19,329		10	1,771	1,771	19,329	59
60	REKEYING ALL INTERIOR AND EXTERIOR DOORS	2015	34,542		10	2,872	2,872	34,542	60
61									61
62	FLOORING ROOMS F110,F120,D113,D128,F9,F115,F3	2015	6,425		10			5,566	62
63	FLOORING ROOMS D107,F8,F19,F117,F4,F7,F111	2016	6,464		10			5,307	63
64	REROOF REHAB AREA	2016	178,404		10			146,437	64
65	ACCOUSTICAL CEILINGS ALL ROOMS	2016	14,265		10			11,644	65
66	WOOD FLOORING HC CORRIDORS	2016	100,515		10			100,515	66
67									67
68	SHOWER ROOM RETILING, ELECTRICAL & PLUMBING	2016	31,679		10			25,080	68
69	NEW CHILLERS AND CONTROLS	2017	1,677,780		40			293,615	69
70	TOTAL (lines 4 thru 69)		\$ 6,830,299	\$		\$ 5,278	\$ 5,278	\$ 4,805,518	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,830,299	\$		\$ 5,278	\$ 5,278	\$ 4,805,518	1
2	Kirks Place Deck for residents adjacent to memory care unit	2017	42,422		20	2,121	2,121	16,791	2
3	Kirks Place Dining and Activities Area repainted	2018	4,445		10	630	630	3,668	3
4	Boiler and exhaust fan upgrade	2019	8,944		10	1,619	1,619	8,435	4
5	Covid UV Lights	2021	24,088		7	3,441	3,441	14,626	5
6	Kirks Place Windows	2022	17,068		10	1,707	1,707	5,405	6
7	Albright Windows	2023	19,922		10	1,162	1,162	3,486	7
8	SARA SERVER	2024	5,105		7	729	729	1,397	8
9	PENDANTS	2024	2,469		5	494	494	947	9
10	VARIOUS HEATING & COOLING	2024	8,225		7	1,175	1,175	2,252	10
11	VARIOUS HEATING & COOLING	2024	3,058		7	437	437	801	11
12	HEALTH CENTER DOOR PROJECT	2024	25,864		10	2,586	2,586	4,741	12
13	CLOSE OUT KIRK'S PLC KITCHEN	2024	4,548		7	650	650	1,083	13
14	VARIOUS HEATING & COOLING	2024	21,281		7	3,040	3,040	4,813	14
15	IDPH UPDATES	2024	2,925		5	585	585	926	15
16	VARIOUS HEATING & COOLING	2024	4,076		7	582	582	825	16
17	PVC DRAIN & SOFFIT	2024	3,979		7	568	568	663	17
18	DOOR REPLACEMENT	2024	3,975		7	568	568	615	18
19	HEALTH CENTER RENOVATIONS	2024	12,614		7	1,802	1,802	3,604	19
20	VARIOUS HEATING AND COOLING	2024	4,287		7	612	612	1,224	20
21	REPAIR SIDING-COURTYARD	2024	11,100		15	740	740	740	21
22	HVAC REPAIRS-THROUGHOUT FACILITY	2024	11,177		15	745	745	745	22
23	INSTALL WATER HEATER	2024	14,593		15	973	973	973	23
24	NEW SHADES-RESIDENT ROOMS	2024	2,856		15	190	190	190	24
25	REPLACE 5 GAUGES AND 8 SPRINKLER HEADS	2024	6,023		15	402	402	402	25
26	REPLACE DOWNSPOUT HEAT TAPE-18 LOCATIONS	2024	20,984		15	1,399	1,399	1,399	26
27	KIRK'S PLACE WALL REPAIR FROM LEAK	2024	5,451		15	363	363	363	27
28	SHADES-RESIDENT ROOMS	2025	5,985		15	399	399	399	28
29	REPAIR CANOPY	2025	2,850		15	190	190	190	29
30	E-WING DINING ROOM REMODEL-CEILING TILES/LIGHT	2025	15,315		15	1,021	1,021	1,021	30
31	BOILER PUMP/BEARING ASSEMBLY REPAIR	2025	4,413		15	294	294	294	31
32	HVAC REPAIRS	2025	11,489		15	766	766	766	32
33	REPLACE DOOR CLOSERS-RESIDENT ROOM AND HALLW	2025	4,300		15	287	287	287	33
34	TOTAL (lines 1 thru 33)		\$ 7,166,130	\$		\$ 37,555	\$ 37,555	\$ 4,889,589	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$7,166,130	\$		\$37,555	\$37,555	\$4,889,589	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	Financial Statement Depreciation			473,548			(473,548)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,166,130	\$473,548		\$37,555	\$(435,993)	\$4,889,589	34

SEE ACCOUNTANTS' PREPARATION 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	\$ 1,821,967	\$	\$ 182,197	\$ 182,197	10	\$ 1,526,173	71
72	Current Year Purchases	90,964		9,096	9,096	10	9,096	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,912,931	\$	\$ 191,293	\$ 191,293		\$ 1,535,269	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	Lift Van	2015 CHRYSLER TOWN & CO	2024	\$ 25,000	\$	\$ 5,000	\$ 5,000	5	\$ 6,250	76
77		2020 Nissan Compact	2024	15,098		1,510	1,510	5	1,510	77
78		2021 Nissan Compact	2024	15,598		1,560	1,560	5	1,560	78
79	See Attached Schedule 13A			84,646		8,464	8,464		8,464	79
80	TOTALS			\$ 140,342	\$	\$ 16,534	\$ 16,534		\$ 17,784	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)	\$ 9,241,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 473,548	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,382	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (228,166)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,442,642	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	HVAC/Water Damage Repairs	12,154	93
94			94
95		\$ 12,154	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.

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	\$	\$	\$	\$ 0		\$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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		2012 Ford Econoline/Trans Repa	2024	\$ 13,274	\$	\$ 1,327	\$ 1,327	5	\$ 1,327	76
77		2024 Chrysler Voyager	2025	71,372		7,137	7,137	5	7,137	77
78							0			78
79							0			79
80	TOTALS			\$ 84,646	\$ 0	\$ 8,464	\$ 8,464		\$ 8,464	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)			\$ 7,272,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 473,548	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 46,019	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (427,529)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 4,898,053	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress		
	Description	Cost
92		\$
93	HVAC/Water Damage Repairs	12,154
94		
95		\$ 12,154

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 18,432 Description: Medical Equipment
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	N/A				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.

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,692	\$ 192,309	\$	2,692	\$ 192,309	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,038	75,372		1,038	75,372	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,638	254,389		3,638	254,389	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				163,614		163,614	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/X-Ray					124,416			124,416	13
14	TOTAL			\$	7,368	\$ 646,486	\$ 163,614	7,368	\$ 810,100	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' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 859,011	\$ 859,011	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 225,000)	2,237,275	2,237,275	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	248	248	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,096,534	\$ 3,096,534	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,736	21,736	13
14	Buildings, at Historical Cost	9,932,477	1,138,143	14
15	Leasehold Improvements, at Historical Cost		6,027,987	15
16	Equipment, at Historical Cost	2,686,808	2,053,273	16
17	Accumulated Depreciation (book methods)	(9,185,911)	(6,442,642)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	710	710	21
22	Other Long-Term Assets (specify: Const in Progress)	12,154	12,154	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,467,974	\$ 2,811,361	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,564,508	\$ 5,907,895	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 493,850	\$ 493,850	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,314	126,314	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,000	17,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Due to Related Parties	2,529,623	2,529,623	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,166,787	\$ 3,166,787	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)	\$ 3,166,787	\$ 3,166,787	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,397,721	\$ 2,741,108	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,564,508	\$ 5,907,895	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$2,728,146	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$2,728,147	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	669,574	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)	\$669,574	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)	\$3,397,721	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 15,639,649	1
2	Discounts and Allowances for all Levels	(1,821,172)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,818,477	3
	B. Ancillary Revenue		
4	Day Care	3,155	4
5	Other Care for Outpatients		5
6	Therapy	482,429	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 485,584	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	71,372	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,159	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	31,157	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 106,688	23
	D. Non-Operating Revenue		
24	Contributions	828,951	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 828,951	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Companion Services/Guest Rooms/Misc Fees</u>	13,879	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,879	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,253,579	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,912,574	31
32	Health Care	6,884,260	32
33	General Administration	3,144,109	33
	B. Capital Expense		
34	Ownership	491,980	34
	C. Ancillary Expense		
35	Special Cost Centers	953,688	35
36	Provider Participation Fee	197,394	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,584,005	40
41	Income before Income Taxes (line 30 minus line 40)**	669,574	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 669,574	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 376,070	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	123,090	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	10,827,399	48
49	Medicare Part A	1,968,943	49
50	Other-(specify) <u>Insurance</u>	522,975	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,818,477	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,808	1,984	\$ 102,655	\$ 51.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,170	12,142	631,981	52.05	3
4	Licensed Practical Nurses	27,063	29,416	1,071,033	36.41	4
5	CNAs & Orderlies	74,120	80,565	2,023,800	25.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,995	3,203	70,125	21.89	10
11	Social Service Workers	12,940	13,897	322,618	23.21	11
12	Dietician					12
13	Food Service Supervisor	5,089	5,192	271,600	52.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,488	42,185	771,336	18.28	15
16	Dishwashers					16
17	Maintenance Workers	7,773	8,558	224,400	26.22	17
18	Housekeepers	18,774	20,473	350,203	17.11	18
19	Laundry					19
20	Administrator	1,673	1,727	259,737	150.40	20
21	Assistant Administrator					21
22	Other Administrative	2,217	2,401	89,516	37.28	22
23	Office Manager					23
24	Clerical	15,137	16,324	475,506	29.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)Nursing Admin	13,105	14,724	523,440	35.55	33
34	TOTAL (lines 1 - 33)	233,352	252,791	\$ 7,187,950 *	\$ 28.43	34

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	Monthly	16,800	L9, C3	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	Monthly	2,800	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	MDS Consulting	Monthly	15,370	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,970		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,272	\$ 607,579	L10, C3	50
51	Licensed Practical Nurses	8,840	560,710	L10, C3	51
52	Certified Nurse Assistants/Aides	20,697	729,883	L10, C3	52
53	TOTAL (lines 50 - 52)	37,809	\$ 1,898,172		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Frances Salinas	President/CEO	0	\$ 152,547
Brett Nelson	Chief Financial Officer	0	64,609
Nicholas Campbell	VP Ops/Administrator	0	42,581
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 259,737
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7		\$	25,857
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 25,857
C. Professional Services			
Vendor/Payee	Type		Amount
ADP/Paylocity	Payroll Processing	\$	14,460
RSM McGladrey	Accounting		20,000
Point Click Care	Accounting Software		76,763
Sage Intacct	Accounting Software		31,831
Matrixcare	Accounting Software		28,322
Triyam	EHS Software		12,594
Provinet	Computer Services		830
Profility	Admissions Software		1,925
Entre Computer Solutions	Computer Services		54,000
OnShift	Scheduling Software		1,175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 241,900
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	68,750
Unemployment Compensation Insurance			385
FICA Taxes			491,007
Employee Health Insurance			1,091,736
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Tuition Reimbursement			25,885
403B Retirement Plan			121,251
Employee Physicals			43,133
Other Employee Benefits			23,290
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,865,437
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			280
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	389		3,890
Association Dues (total from pg 22, #4)			
Misc Dues and Subscriptions			1,089
Misc Licences and Fees			3,864
Less: Public Relations Expense	(		)
PAC and Lobbying payments	(		)
All non-allowable advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,123
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			698
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	698

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' PREPARATION REPORT

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|------------------|--------------|
| | |
| | |
| <u>N/A</u> | |
| | |
| | Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|------------|--------------|
| | |
| | |
| <u>N/A</u> | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|------------|--------------|
| | |
| | |
| <u>N/A</u> | |
| | |
| | |
| | Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 64,917 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 197,394
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM McGladrey
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.