

		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: 0050633 Facility Name: Willow Rose Rehab & Health Address: 410 Fletcher Jerseyville 62052 County: Jersey Telephone Number: (618) 498-6427 Fax # (618) 639-3339 HFS ID Number: Date of Initial License for Current Owners: 12/7/2006 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Mike Kocher Telephone Number: (309) 689-5850 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 1/1/2016 to 12/31/2016 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) (Type or Print Name) Mark B. Petersen (Title) Chief Executive Officer Paid Preparer (Signed) (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
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Facility Name & ID Number Willow Rose Rehab & Health

0050633 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 N/A

1	2	3	4		
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period		
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	13,386	3,909	1,392	18,687	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,386	3,909	1,392	18,687	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.24%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES X NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 12/7/2006

J. Was the facility purchased or leased after January 1, 1978? YES X Date 12/7/2006 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 98 and days of care provided 945

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL X CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Willow Rose Rehab & Health # 0050633 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	125,461	11,038		136,499		136,499	4,163	140,662			1
2	Food Purchase		134,152		134,152		134,152	(5,983)	128,169			2
3	Housekeeping	108,295	16,071		124,366		124,366	73	124,439			3
4	Laundry	27,040	5,350	793	33,183		33,183		33,183			4
5	Heat and Other Utilities			100,360	100,360		100,360	243	100,603			5
6	Maintenance	31,699	10,028	27,439	69,166		69,166	2,273	71,439			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	292,495	176,639	128,592	597,726		597,726	769	598,495			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	905,648	88,533	5,618	999,799		999,799	(2,234)	997,565			10
10a	Therapy			117,458	117,458		117,458		117,458			10a
11	Activities	45,028	102	107	45,237		45,237	(2,462)	42,775			11
12	Social Services	24,432			24,432		24,432		24,432			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	975,108	88,635	132,183	1,195,926		1,195,926	(4,696)	1,191,230			16
	C. General Administration											
17	Administrative			229,700	229,700		229,700	(160,450)	69,250			17
18	Directors Fees											18
19	Professional Services			6,923	6,923		6,923	16,875	23,798			19
20	Dues, Fees, Subscriptions & Promotions			8,288	8,288		8,288	443	8,731			20
21	Clerical & General Office Expenses	28,232	2,906	11,895	43,033		43,033	48,477	91,510			21
22	Employee Benefits & Payroll Taxes			176,394	176,394		176,394	27,137	203,531			22
23	Inservice Training & Education							93	93			23
24	Travel and Seminar							45	45			24
25	Other Admin. Staff Transportation			4,839	4,839		4,839	3,818	8,657			25
26	Insurance-Prop.Liab.Malpractice			30,749	30,749		30,749	538	31,287			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	28,232	2,906	468,788	499,926		499,926	(63,024)	436,902			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,295,835	268,180	729,563	2,293,578		2,293,578	(66,951)	2,226,627			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			116,827	116,827		116,827	17,605	134,432			30
31	Amortization of Pre-Op. & Org.							9,734	9,734			31
32	Interest			87,001	87,001		87,001	12,597	99,598			32
33	Real Estate Taxes			51,847	51,847		51,847	247	52,094			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,064	20,064		20,064	873	20,937			35
36	Other (specify):*											36
37	TOTAL Ownership			275,739	275,739		275,739	41,056	316,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,051		37,051		37,051		37,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,440	168,440		168,440		168,440			42
43	Other (specify):*		109	13,922	14,031		14,031	(14,031)				43
44	TOTAL Special Cost Centers		37,160	182,362	219,522		219,522	(14,031)	205,491			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,295,835	305,340	1,187,664	2,788,839		2,788,839	(39,926)	2,748,913			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	(6,059)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,522	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(390)	43		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	(7,142)	43		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	(1,798)	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	(9,575)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,443)		\$	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)	(21,483)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,483)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (39,926)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,992)	43	1
2	X-Rays-Part A	(522)	43	2
3	Offset Transportation Revenue	(2,462)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(55)	21	4
5	Offset Miscellaneous Nursing Supplies Revenue	(2,357)	10	5
6	Disallowed Special Events	(772)	43	6
7	Disallowed Pet Expense	(1,415)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,575)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	4,163	0	0	0	0	0	0	0	0	0	4,163	1
2	Food Purchase	(6,059)	76	0	0	0	0	0	0	0	0	0	(5,983)	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	243	0	0	0	0	0	0	0	0	0	243	5
6	Maintenance	0	2,273	0	0	0	0	0	0	0	0	0	2,273	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,059)	6,828	0	0	0	0	0	0	0	0	0	769	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	(2,357)	123	0	0	0	0	0	0	0	0	0	(2,234)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,462)	0	0	0	0	0	0	0	0	0	0	(2,462)	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	(4,819)	123	0	0	0	0	0	0	0	0	0	(4,696)	16
	C. General Administration													
17	Administrative	0	(160,450)	0	0	0	0	0	0	0	0	0	(160,450)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,602	0	6,273	0	0	0	0	0	0	0	16,875	19
20	Fees, Subscriptions & Promotions	0	0	443	0	0	0	0	0	0	0	0	443	20
21	Clerical & General Office Expenses	(55)	0	48,532	0	0	0	0	0	0	0	0	48,477	21
22	Employee Benefits & Payroll Taxes	0	0	27,137	0	0	0	0	0	0	0	0	27,137	22
23	Inservice Training & Education	0	0	93	0	0	0	0	0	0	0	0	93	23
24	Travel and Seminar	0	0	45	0	0	0	0	0	0	0	0	45	24
25	Other Admin. Staff Transportation	0	0	3,818	0	0	0	0	0	0	0	0	3,818	25
26	Insurance-Prop.Liab.Malpractice	0	0	538	0	0	0	0	0	0	0	0	538	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(55)	(149,848)	80,606	6,273	0	0	0	0	0	0	0	(63,024)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,933)	(142,897)	80,606	6,273	0	0	0	0	0	0	0	(66,951)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Rose Rehab & Health # 0050633 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	6,522	0	10,740	343	0	0	0	0	0	0	0	17,605	30
31	Amortization of Pre-Op. & Org.	0	0	0	9,734	0	0	0	0	0	0	0	9,734	31
32	Interest	(1)	0	315	12,283	0	0	0	0	0	0	0	12,597	32
33	Real Estate Taxes	0	0	247	0	0	0	0	0	0	0	0	247	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	873	0	0	0	0	0	0	0	0	873	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,521	0	12,175	22,360	0	0	0	0	0	0	0	41,056	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):*	(14,031)	0	0	0	0	0	0	0	0	0	0	(14,031)	43
44	TOTAL Special Cost Centers	(14,031)	0	0	0	0	0	0	0	0	0	0	(14,031)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(18,443)	(142,897)	92,781	28,633	0	0	0	0	0	0	0	(39,926)	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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,163	\$ 4,163	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	76	76	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	73	73	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	243	243	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,273	2,273	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	123	123	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	229,700	Petersen Health Care Management, Inc.	100.00%	69,250	(160,450)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	10,602	10,602	12
13	V								13
14	Total			\$ 229,700			\$ 86,803	\$ * (142,897)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 443	\$ 443	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	48,532	48,532	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	27,137	27,137	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	93	93	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	45	45	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,818	3,818	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	538	538	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	10,740	10,740	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	315	315	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	247	247	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	873	873	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 92,781	\$ * 92,781	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Network, LLC	100.00%	6,273	6,273	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Network, LLC	100.00%	343	343	33
34	V	31	Amortization		Petersen Health Network, LLC	100.00%	9,734	9,734	34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	12,283	12,283	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total			\$			\$ 28,633	\$ * 28,633	39

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

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Willow Rose Rehab & Health # 0050633 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											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

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	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	Dietary	Resident Days	1,521,544	75	\$ 312,540	\$ 357,910	20,267	\$ 4,163	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	20,267	76	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	20,267	73	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	20,267	243	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	20,267	2,273	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	20,267	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	20,267	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	20,267	123	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	20,267	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	20,267	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	20,267	69,250	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	20,267	10,602	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	20,267	443	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	20,267	48,532	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	20,267	27,137	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	20,267	93	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	20,267	45	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	20,267	3,818	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	20,267	538	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	20,267	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	20,267	10,740	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	20,267	315	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	20,267	247	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	20,267	873	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 179,584	25

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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

Petersen Health Network, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

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	Dietary	Resident Days	251,294	13	\$	20,267	\$	1
2	2	Food	Resident Days	251,294	13		20,267		2
3	3	Housekeeping	Resident Days	251,294	13		20,267		3
4	4	Laundry	Resident Days	251,294	13		20,267		4
5	5	Utilities	Resident Days	251,294	13		20,267		5
6	6	Maintenance	Resident Days	251,294	13		20,267		6
7	7	Mgmt. Allocation of Benefits	Resident Days	251,294	13		20,267		7
8	10	Nursing and Medical Records	Resident Days	251,294	13		20,267		8
9	15	Mgmt. Allocation of Benefits	Resident Days	251,294	13		20,267		9
10	17	Administrative	Resident Days	251,294	13		20,267		10
11	19	Professional Services	Resident Days	251,294	13	77,776	20,267	6,273	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	251,294	13		20,267		12
13	21	Clerical and General Office	Resident Days	251,294	13		20,267		13
14	22	Employee Benefits & Payroll	Resident Days	251,294	13		20,267		14
15	23	Inservice Training & Education	Resident Days	251,294	13		20,267		15
16	24	Travel and Seminar	Resident Days	251,294	13		20,267		16
17	25	Other Admin. Staff Transport.	Resident Days	251,294	13		20,267		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	251,294	13		20,267		18
19	30	Depreciation	Resident Days	251,294	13	4,252	20,267	343	19
20	31	Amortization	Resident Days	251,294	13	120,699	20,267	9,734	20
21	32	Interest	Resident Days	251,294	13	152,300	20,267	12,283	21
22	33	Real Estate Taxes	Resident Days	251,294	13		20,267		22
23	34	Rent-Facility and Grounds	Resident Days	251,294	13		20,267		23
24	35	Rent-Equipment & Vehicles	Resident Days	251,294	13		20,267		24
25	TOTALS					\$ 355,027	\$	28,633	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	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 1,890,756	\$ 1,682,773	12/31/34	Varies	\$ 87,001	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,890,756	\$ 1,682,773			\$ 87,001	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(1)	10	
11								Home Office Allocation-PHN			12,283	11	
12								Home Office Allocation-PHCM			315	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 12,597	14	
15	TOTALS (line 9+line14)						\$ 1,890,756	\$ 1,682,773			\$ 99,598	15	

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Rose Rehab & Health COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0050633

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 04-208-024-00	Long-Term Care Facility	\$ 50,178.98	\$ 50,178.98
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 50,178.98	\$ 50,178.98

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 X NO

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 22,627

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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: 561,304

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 9,734

4. Dates Incurred: 2013-2014

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	Facility	153,475	2006	\$ 110,000	1
2					2
3	TOTALS	153,475		\$ 110,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	98		2006	1974	\$ 2,490,000	\$	30	\$ 83,666	\$ 83,666	\$ 796,160
5										
6										
7										
8										
	Improvement Type**									
9	Signage		2007		3,953		15	264	264	2,508
10	Carpeting-Offices		2007		14,995		10	1,555	1,555	14,772
11	Fire Alarm System		2007		7,750		15	517	517	5,181
12	Egress Lighting		2007		4,435		15	296	296	2,812
13	Tile-Therapy Room		2007		5,152		15	343	343	4,458
14	Water Heater		2009		6,300		5			6,300
15	Concrete in Parking Lot		2010		7,500		15	500	500	3,250
16	A/C Unit		2011		7,417		15	494	494	2,717
17	Smoke Detector Installation		2012		5,805		15	388	388	1,746
18	Carpeting-Dining Room and Main Floor		2013		16,969		15	1,131	1,131	4,815
19	Sprinkler System Replacement		2013		60,900		25	2,436	2,436	63,336
20	Water Heater		2013		3,656		7	522	522	1,827
21	A/C Unit-Roof Top		2014		6,458		15	431	431	1,078
22	Water Heater		2014		2,991		7	427	427	1,068
23	Flooring, New Doors, Hallway Opening, Drywall Repair-Dining Room		2014		15,578		15	1,039	1,039	2,598
24	Exterior Building Siding Replacement		2014		35,377		25	1,415	1,415	3,538
25	Door Alarm System		2015		5,522		7	790	790	1,185
26	Tiling for 4 Shower Rooms		2015		24,800		15	1,654	1,654	2,481
27	Water Leak Repair		2016		3,220		7	230	230	230
28	Electrical Repair		2016		13,675		7	977	977	977
29	Flooring for Hallway		2016		3,136		10	157	157	157
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			1,834			(1,834)		63
64	Building Booked			99,235			(99,235)		64
65	Building Improvement Booked			13,599			(13,599)		65
66									66
67	2016-Home Office Allocation-Building Improvements		8,948			215	215		67
68	2016-Home Office Allocation-Land Improvements		823			53	53		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,755,360	\$ 114,668		\$ 99,500	\$ (15,168)	\$ 923,194	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	\$446,744	\$2,159	\$24,117	\$21,958	5-10 yrs.	\$433,243	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,815	10,815			74
75	TOTALS	\$446,744	\$2,159	\$34,932	\$32,773		\$433,243	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	Facility	2007 Ford Econoline Van	2007	\$27,198	\$	\$	\$		\$27,198	76
77										77
78										78
79										79
80	TOTALS			\$27,198	\$	\$	\$		\$27,198	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)	\$3,339,302	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$116,827	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$134,432	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$17,605	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,383,635	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			93
94	N/A		94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

YES

NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy:
- YES

NO
- Terms: *

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

15. Is Movable equipment rental included in building rental?
- YES

NO
16. Rental Amount for movable equipment: \$ 20,937
- Description: See Attached Schedule 14A
- (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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

Willow Rose Rehab & Health
0050633

Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	16,190
Dishwasher		763
Copier		3,111
Home Office Allocation		873
		<u>20,937</u>
		<u><u>20,937</u></u>

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)	\$			

- (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.

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	

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	10A(3)	hrs	\$	3,441	\$ 51,610	\$	3,441	\$ 51,610	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,099	16,483		1,099	16,483	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,291	49,365		3,291	49,365	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				37,051		37,051	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			\$	7,831	\$ 117,458	\$ 37,051	7,831	\$ 154,509	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	\$ 115,649	\$ 115,649	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,545)	987,905	987,905	3
4	Supply Inventory (priced at Cost)	11,567	11,567	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,758	28,758	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	286	286	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,144,165	\$ 1,144,165	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	137,500	110,000	13
14	Buildings, at Historical Cost	2,480,880	2,498,948	14
15	Leasehold Improvements, at Historical Cost	261,588	256,412	15
16	Equipment, at Historical Cost	473,942	473,942	16
17	Accumulated Depreciation (book methods)	(1,564,130)	(1,383,635)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,789,780	\$ 1,955,667	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,933,945	\$ 3,099,832	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 395,481	\$ 395,481	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,910	72,910	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,602	23,602	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,684	51,684	32
33	Accrued Interest Payable	7,418	7,418	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	20,763	20,763	36
37	Accrued Management Fees	147,349	147,349	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 719,207	\$ 719,207	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,682,773	1,682,773	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)	\$ 1,682,773	\$ 1,682,773	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,401,980	\$ 2,401,980	46
47	TOTAL EQUITY(page 18, line 24)	\$ 531,965	\$ 697,852	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,933,945	\$ 3,099,832	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 159,770	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 159,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	372,192	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)	\$ 372,192	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)	\$ 531,965	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 3,006,858	1
2	Discounts and Allowances for all Levels	(171,546)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,835,312	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	218,396	6
7	Oxygen	976	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 219,372	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	6,059	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,280	20
21	Other Medical Services	16,539	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 101,472	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,462	28
28a	<u>Miscellaneous Revenue</u>	2,412	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,874	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,161,031	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	597,726	31
32	Health Care	1,195,926	32
33	General Administration	499,926	33
	B. Capital Expense		
34	Ownership	275,739	34
	C. Ancillary Expense		
35	Special Cost Centers	51,082	35
36	Provider Participation Fee	168,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,788,839	40
41	Income before Income Taxes (line 30 minus line 40)**	372,192	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 372,192	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,895,011	44
45	Private Pay - Net Inpatient Revenue	604,421	45
46	Medicare - Net Inpatient Revenue	177,232	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	158,648	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,835,312	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	2,721	2,785	\$ 65,039	\$ 23.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,162	8,419	202,696	24.08	3
4	Licensed Practical Nurses	9,608	9,758	161,207	16.52	4
5	CNAs & Orderlies	33,332	33,968	399,381	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,683	2,841	33,390	11.75	8
9	Activity Director	1,670	1,892	22,280	11.78	9
10	Activity Assistants					10
11	Social Service Workers	1,973	2,171	24,432	11.25	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,559	13.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,288	9,941	96,902	9.75	15
16	Dishwashers					16
17	Maintenance Workers	1,889	1,991	31,699	15.92	17
18	Housekeepers	10,269	10,794	108,295	10.03	18
19	Laundry	2,984	3,034	27,040	8.91	19
20	Administrator	2,080	2,080	69,250	33.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	28,232	13.57	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care CPC	2,080	2,080	43,935	21.12	32
33	Other(specify) Transportation	2,481	2,496	22,748	9.11	33
34	TOTAL (lines 1 - 33)	95,380	98,410	\$ 1,365,085 *	\$ 13.87	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	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,679	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	231	L10A, C3	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)	4	\$ 13,910		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2016

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
David Serrano		Administrator	0	\$ 69,250	Workers' Compensation Insurance		\$ 50,007	IDPH License Fee		\$	
					Unemployment Compensation Insurance		26,959	Advertising: Employee Recruitment		634	
					FICA Taxes		95,542	Health Care Worker Background Check			
					Employee Health Insurance		2,126	(Indicate # of checks performed 3)		55	
					Employee Meals			Patient Background Checks		1,036	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		950	
					Employee Relations		1,760	Miscellaneous Dues & Subscriptions		5,613	
					Home Office Allocation		27,137	Home Office Allocation		443	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 69,250							
B. Administrative - Other											
Description			Amount								
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 229,700								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 229,700	TOTAL (agree to Schedule V, line 22, col.8)			\$ 203,531	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,731
(Attach a copy of any management service agreement)					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services		Type	Amount	Description		Line #	Amount	Description		Amount	
Vendor/Payee								Out-of-State Travel		\$	
E-Health Data Solutions		Computer Services	\$ 3,043								
Grafton Technologies		Computer Services	646								
Honkamp Krueger & Co.		Accounting Fees	2,812	N/A							
Lucie, Scalf & Bougher Escrow		Legal Fees	422					In-State Travel			
								Seminar Expense			
								Home Office Allocation		45	
								Entertainment Expense		()	
								(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL		\$ 45	
(For legal fee disclosure, see page 39 of instructions)			\$ 6,923								

* Attach copy of IMRF notifications

**See instructions.

Willow Rose Rehab & Health
0050633
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,923
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	47
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	82
Healthcare Resources International	Legal	981
Hunziker Law	Legal	98
Lexis Nexis	Legal	8
Wells Fargo	Legal	449
CliftonLarson Allen	Accountants	425
Ginoli & Co.	Accountants	5,467
Wells Fargo	Accountants	1,172
Miscellaneous	Computer Services	54
Change Healthcare	Computer Services	8
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	3,732
Stratus Networks	Computer Services	380
Kemper Technology	Computer Services	250
AT&T	Computer Services	5
Ability Network	Computer Services	1,591
CIA/N	Computer Services	190
Comcast	Computer Services	31
CCH	Computer Services	13
Charter Communications	Computer Services	37
Allscripts	Computer Services	555
ATS	Computer Services	250
Allpayer Exchange	Computer Services	13
Optimizer	Other Prof Fees	38
Ankura	Other Prof Fees	290
David Budde	Other Prof Fees	33
Bruner, Cooper, Zuck	Other Prof Fees	84
Marotta, Gund, Budd, Dzerda	Other Prof Fees	521
Professional Software and Services	Other Prof Fees	21
Hughes Valuation Services	Other Prof Fees	26
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)	<u><u>23,798</u></u>
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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?
If YES, give association name and amount.

Yes
IHCA \$5388
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 23,068 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 168,440
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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? 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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 6,059
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 2,462

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(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.
Attach invoices and a summary of services for all architect and appraisal fees

N/A

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	125,461	11,038	0	136,499	0	136,499	4,163	140,662
2. Food Purchase	0	134,152	0	134,152	0	134,152	-5,983	128,169
3. Housekeeping	108,295	16,071	0	124,366	0	124,366	73	124,439
4. Laundry	27,040	5,350	793	33,183	0	33,183	0	33,183
5. Heat and Other Utilities	0	0	100,360	100,360	0	100,360	243	100,603
6. Maintenance	31,699	10,028	27,439	69,166	0	69,166	2,273	71,439
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	292,495	176,639	128,592	597,726	0	597,726	769	598,495
9. Medical Director	0	0	9,000	9,000	0	9,000	0	9,000
10. Nursing & Medical Records	905,648	88,533	5,618	999,799	0	999,799	-2,234	997,565
10a. Therapy	0	0	117,458	117,458	0	117,458	0	117,458
11. Activities	45,028	102	107	45,237	0	45,237	-2,462	42,775
12. Social Services	24,432	0	0	24,432	0	24,432	0	24,432
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	975,108	88,635	132,183	1,195,926	0	1,195,926	-4,696	#####
17. Administrative	0	0	229,700	229,700	0	229,700	-160,450	69,250
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	6,923	6,923	0	6,923	16,875	23,798
20. Fees, Subscriptions & Promotion	0	0	8,288	8,288	0	8,288	443	8,731
21. Clerical & General Office	28,232	2,906	11,895	43,033	0	43,033	48,477	91,510
22. Employee Benefits & Payroll	0	0	176,394	176,394	0	176,394	27,137	203,531
23. Inservice Training & Education	0	0	0	0	0	0	93	93
24. Travel and Seminar	0	0	0	0	0	0	45	45
25. Other Admin. Staff Trans	0	0	4,839	4,839	0	4,839	3,818	8,657
26. Insurance-Prop.Liab.Malpractice	0	0	30,749	30,749	0	30,749	538	31,287
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	28,232	2,906	468,788	499,926	0	499,926	-63,024	436,902
29. Total General Administrative	1,295,835	268,180	729,563	2,293,578	0	2,293,578	-66,951	#####
30. Depreciation	0	0	116,827	116,827	0	116,827	17,605	134,432
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	9,734	9,734
32. Interest	0	0	87,001	87,001	0	87,001	12,597	99,598
33. Real Estate	0	0	51,847	51,847	0	51,847	247	52,094
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	20,064	20,064	0	20,064	873	20,937
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	275,739	275,739	0	275,739	41,056	316,795
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	37,051	0	37,051	0	37,051	0	37,051
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	168,440	168,440	0	168,440	0	168,440
43. Other (specify):*	0	109	13,922	14,031	0	14,031	-14,031	0
44. Total Special Cost Ce	0	37,160	182,362	219,522	0	219,522	-14,031	205,491
45. Grand Total	1,295,835	305,340	1,187,664	2,788,839	0	2,788,839	-39,926	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	115,649	115,649
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	987,905	987,905
4. Supply Inventory	11,567	11,567
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,758	28,758
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	286	286
10. Total current assets	1,144,165	1,144,165
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	137,500	110,000
14. Buildings, at Historical Cost	2,480,880	2,498,948
15. Leasehold Improvements, Historical Cost	261,588	256,412
16. Equipment, at Historical Cost	473,942	473,942
17. Accumulated Depreciation (book methods) #####		-1,383,635
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,789,780	1,955,667
25. Total Assets	2,933,945	3,099,832
CURRENT LIABILITIES		
26. Accounts Payable	395,481	395,481
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	72,910	72,910
31. Accrued Taxes Payable	23,602	23,602
32. Accrued Real Estate Taxes	51,684	51,684
33. Accrued Interest Payable	7,418	7,418
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	20,763	20,763
37. Other Current Liabilities (specify):	147,349	147,349
38. Total Current Liabilities	719,207	719,207
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,682,773	1,682,773
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,682,773	1,682,773
46.Total Liabilities	2,401,980	2,401,980
47.Total Equity	531,965	697,852
48.Total Liabilities and Equity	2,933,945	3,099,832

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,006,858
2. Discounts and Allowances for all Levels	-171,546
Subtotal - Inpatient Care	2,835,312
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	218,396
7. Oxygen	976
Subtotal - Ancillary Revenue	219,372
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	6,059
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	75,594
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	3,280
21. Other Medical Services	16,539
22. Laundry	0
Subtotal - Other Operating Revenue	101,472
24. Contributions	0
25. Interest and Other Investments Income	1
Subtotal - Non-Operating Revenue	1
27. Other Revenue (specify):	2,462
28. Other Revenue (specify):	2,412
Subtotal - Other Revenue	4,874
30. Total Revenue	3,161,031
31. General Services	587,988
32. Health Care	1,112,814
33. General Administration	495,177
34. Ownership	275,534
35. Special Cost Centers	41,433
35. Provider Participation Fee	164,803
37. Other	0
40. Total Expenses	2,677,749
41. Income Before Income Taxes	483,282
42. Income Taxes	0
43. Net Income or Loss for the Year	483,282