



Facility Name & ID Number Willow Rose Rehab & Health

# 0048553 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,406	4,841	1,643	24,890	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,406	4,841	1,643	24,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.58%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  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 12/07/2006

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/07/2006 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 98 and days of care provided 1,643

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Willow Rose Rehab & Health # 0048553 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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
	<b>A. General Services</b>										
1	Dietary	116,537	12,548	3,724	132,809		132,809	2,083	134,892		1
2	Food Purchase		124,733		124,733		124,733	(4,328)	120,405		2
3	Housekeeping	86,176	20,951		107,127		107,127	34	107,161		3
4	Laundry	47,079	14,207		61,286		61,286	1	61,287		4
5	Heat and Other Utilities			118,670	118,670		118,670	356	119,026		5
6	Maintenance	23,562	11,559	30,668	65,789		65,789	3,045	68,834		6
7	Other (specify):* Home Off. Ben. All.							950	950		7
8	<b>TOTAL General Services</b>	273,354	183,998	153,062	610,414		610,414	2,141	612,555		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	815,982	45,212	2,909	864,103		864,103	5,533	869,636		10
10a	Therapy	15,179	1,117	257,921	274,217		274,217		274,217		10a
11	Activities	18,327	1,019	2,290	21,636		21,636		21,636		11
12	Social Services	16,975	234		17,209		17,209		17,209		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,224	1,224		15
16	<b>TOTAL Health Care and Programs</b>	866,463	47,582	272,120	1,186,165		1,186,165	6,757	1,192,922		16
	<b>C. General Administration</b>										
17	Administrative	51,000		57,000	108,000		108,000	(41,495)	66,505		17
18	Directors Fees										18
19	Professional Services			4,262	4,262		4,262	5,679	9,941		19
20	Dues, Fees, Subscriptions & Promotions			7,116	7,116		7,116	712	7,828		20
21	Clerical & General Office Expenses	42,545	7,461	7,678	57,684		57,684	38,292	95,976		21
22	Employee Benefits & Payroll Taxes			164,730	164,730		164,730		164,730		22
23	Inservice Training & Education			251	251		251	448	699		23
24	Travel and Seminar							646	646		24
25	Other Admin. Staff Transportation			2,588	2,588		2,588	2,479	5,067		25
26	Insurance-Prop.Liab.Malpractice			21,057	21,057		21,057	1,101	22,158		26
27	Other (specify):* Home Off. Ben. All.							10,095	10,095		27
28	<b>TOTAL General Administration</b>	93,545	7,461	264,682	365,688		365,688	17,957	383,645		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,233,362	239,041	689,864	2,162,267		2,162,267	26,855	2,189,122		29

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

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

Facility Name &amp; ID Number

Willow Rose Rehab &amp; Health

#0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			165,711	165,711		165,711	(32,780)	132,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			205,069	205,069		205,069	9,031	214,100			32
33	Real Estate Taxes			54,758	54,758		54,758	815	55,573			33
34	Rent-Facility & Grounds							50	50			34
35	Rent-Equipment & Vehicles			7,613	7,613		7,613	656	8,269			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			433,151	433,151		433,151	(22,228)	410,923			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,150		71,150		71,150		71,150			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,688	44,688		44,688		44,688			42
43	Other (specify):* Non-allowable Cost	17,391	720	51,926	70,037		70,037	(70,037)				43
44	<b>TOTAL Special Cost Centers</b>	17,391	71,870	96,614	185,875		185,875	(70,037)	115,838			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,250,753	310,911	1,219,629	2,781,293		2,781,293	(65,410)	2,715,883			45

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

\*\*See schedule of adjustments attached at end of cost 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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,400)	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	(35,660)	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	(873)	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				18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,689)	43		24
25	Fund Raising, Advertising and Promotional	(23,931)	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 Pg. 5A	(7,907)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (110,485)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	45,075	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 45,075</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (65,410)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

Willow Rose Rehab & Health

ID# 0048553

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,206)	43	1
2	X-Rays-Part A	(1,313)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(188)	21	3
4	Disallowed Dues	(200)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(7,907)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Willow Rose Rehab &amp; Health

# 0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	2,083	0	0	0	0	0	0	0	0	0	2,083	1
2	Food Purchase	(4,400)	72	0	0	0	0	0	0	0	0	0	(4,328)	2
3	Housekeeping	0	24	0	10	0	0	0	0	0	0	0	34	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	356	0	0	0	0	0	0	0	0	0	356	5
6	Maintenance	0	2,901	0	144	0	0	0	0	0	0	0	3,045	6
7	Other (specify):*	0	950	0	0	0	0	0	0	0	0	0	950	7
8	<b>TOTAL General Services</b>	<b>(4,400)</b>	<b>6,387</b>	<b>0</b>	<b>154</b>	<b>0</b>	<b>2,141</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,507	0	26	0	0	0	0	0	0	0	5,533	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,224	0	0	0	0	0	0	0	0	0	1,224	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>6,731</b>	<b>0</b>	<b>26</b>	<b>0</b>	<b>6,757</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(41,495)	0	0	0	0	0	0	0	0	0	(41,495)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,209	0	1,470	0	0	0	0	0	0	0	5,679	19
20	Fees, Subscriptions & Promotions	(200)	0	912	0	0	0	0	0	0	0	0	712	20
21	Clerical & General Office Expenses	(188)	0	35,305	3,175	0	0	0	0	0	0	0	38,292	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	406	42	0	0	0	0	0	0	0	448	23
24	Travel and Seminar	0	0	646	0	0	0	0	0	0	0	0	646	24
25	Other Admin. Staff Transportation	0	0	2,341	138	0	0	0	0	0	0	0	2,479	25
26	Insurance-Prop.Liab.Malpractice	0	0	953	148	0	0	0	0	0	0	0	1,101	26
27	Other (specify):*	0	0	10,095	0	0	0	0	0	0	0	0	10,095	27
28	<b>TOTAL General Administration</b>	<b>(388)</b>	<b>(37,286)</b>	<b>50,658</b>	<b>4,973</b>	<b>0</b>	<b>17,957</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(4,788)</b>	<b>(24,168)</b>	<b>50,658</b>	<b>5,153</b>	<b>0</b>	<b>26,855</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Rose Rehab & Health

# 0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(35,660)	0	2,472	408	0	0	0	0	0	0	0	(32,780)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,297	4,734	0	0	0	0	0	0	0	9,031	32
33	Real Estate Taxes	0	0	815	0	0	0	0	0	0	0	0	815	33
34	Rent-Facility & Grounds	0	0	50	0	0	0	0	0	0	0	0	50	34
35	Rent-Equipment & Vehicles	0	0	656	0	0	0	0	0	0	0	0	656	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(35,660)</b>	<b>0</b>	<b>8,290</b>	<b>5,142</b>	<b>0</b>	<b>(22,228)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(70,037)	0	0	0	0	0	0	0	0	0	0	(70,037)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(70,037)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(70,037)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(110,485)</b>	<b>(24,168)</b>	<b>58,948</b>	<b>10,295</b>	<b>0</b>	<b>(65,410)</b>	<b>45</b>						

Facility Name & ID Number

Willow Rose Rehab & Health

# 0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,083	\$ 2,083	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	72	72	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	356	356	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,901	2,901	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	950	950	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,507	5,507	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,224	1,224	10
11	V	17 Administrative	57,000	Petersen Health Care, Inc.	100.00%	15,505	(41,495)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,209	4,209	12
13	V							13
14	Total		\$ 57,000			\$ 32,832	\$ * (24,168)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 912	\$ 912	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,305	35,305	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	406	406	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	646	646	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,341	2,341	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	953	953	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,095	10,095	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,472	2,472	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,297	4,297	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	815	815	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	50	50	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	656	656	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		\$			\$ 58,948	\$ * 58,948	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 Companies, LLC	100.00%	\$ 0	\$ 0 15
16	V	2 Food		Petersen Companies, LLC	100.00%	0	0 16
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	10	10 17
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0	0 18
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0	0 19
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	144	144 20
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 21
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	26	26 22
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0	0 23
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 24
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0	0 25
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	1,470	1,470 26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Companies, LLC	100.00%	0	0 27
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	3,175	3,175 28
29	V	23 Inservice Training and Education		Petersen Companies, LLC	100.00%	42	42 29
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0	0 30
31	V	25 Other Admin. Staff Transportation		Petersen Companies, LLC	100.00%	138	138 31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Companies, LLC	100.00%	148	148 32
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 33
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	408	408 34
35	V	32 Interest		Petersen Companies, LLC	100.00%	4,734	4,734 35
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0	0 36
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0	0 37
38	V	35 Rent-Equipment and Vehicles		Petersen Companies, LLC	100.00%	0	0 38
39	Total		\$			\$ 10,295	\$ * 10,295 39

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

Facility Name &amp; ID Number

Willow Rose Rehab &amp; Health

# 0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.02	1.85	Salary	\$ 15,505	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,505		13

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

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

Facility Name &amp; ID Number Willow Rose Rehab &amp; Health

# 0048553 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	24,890	\$ 2,083	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	24,890	72	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	24,890	24	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	24,890	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	24,890	356	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	24,890	2,901	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	24,890	950	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	24,890	5,507	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	24,890	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	24,890	1,224	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	24,890	15,505	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	24,890	4,209	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	24,890	912	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	24,890	35,305	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	24,890	406	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	24,890	646	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	24,890	2,341	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	24,890	953	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	24,890	10,095	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	24,890	2,472	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	24,890	4,297	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	24,890	815	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	24,890	50	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	24,890	656	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 91,780	25

Facility Name &amp; ID Number Willow Rose Rehab &amp; Health

# 0048553 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

## 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 Companies, 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	179,368	12	\$	24,890	\$	1
2	2	Food	Resident Days	179,368	12		24,890		2
3	3	Housekeeping	Resident Days	179,368	12	70	24,890	10	3
4	4	Laundry	Resident Days	179,368	12		24,890		4
5	5	Utilities	Resident Days	179,368	12		24,890		5
6	6	Maintenance	Resident Days	179,368	12	1,038	24,890	144	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		24,890		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	24,890	26	8
9	10A	Therapy	Resident Days	179,368	12		24,890		9
10	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		24,890		10
11	17	Administrative	Resident Days	179,368	12		24,890		11
12	19	Professional Services	Resident Days	179,368	12	10,592	24,890	1,470	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		24,890		13
14	21	Clerical and General Office	Resident Days	179,368	12	22,877	24,890	3,175	14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	24,890	42	15
16	24	Travel and Seminar	Resident Days	179,368	12		24,890		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	24,890	138	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	24,890	148	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		24,890		19
20	30	Depreciation	Resident Days	179,368	12	2,941	24,890	408	20
21	32	Interest	Resident Days	179,368	12	34,114	24,890	4,734	21
22	33	Real Estate Taxes	Resident Days	179,368	12		24,890		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		24,890		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		24,890		24
25	TOTALS					\$ 74,184	\$	\$ 10,295	25

Facility Name & ID Number

Willow Rose Rehab & Health

# 0048553

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	LaSalle Bank		X	Mortgage	Varies	10/31/07	\$ 2,400,000	\$ 2,391,432	10/31/12	Varies	\$ 197,204	1				
2	Associated Bank		X	Vehicle	\$546.18	11/14/07	27,198	26,821	11/14/12	0.0748	170	2				
3												3				
4							Home Office Allocation				9,031	4				
5							Amortization Expense				7,695	5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>				\$546.18		\$ 2,427,198	\$ 2,418,253			\$ 214,100	9				
<b>B. Non-Facility Related*</b>																
10												10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 2,427,198	\$ 2,418,253			\$ 214,100	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.)

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Willow Rose Rehab & Health COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0048553

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-208-024-00</u>	<u>Long-Term Care Facility</u>	\$ <u>37,011.18</u>	\$ <u>37,011.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>37,011.18</u>	\$ <u>37,011.18</u>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Willow Rose Rehab & Health

# 0048553

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,627 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: Facility, 153,475, 2006, \$ 110,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 153,475, (blank), \$ 110,000, 3.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	\$ 2,470,000	\$	30	\$ 82,333	\$ 82,333	\$ 123,500	4
5										5
6										6
7	Home Office Allocation			13,876			339	339		7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements	2006		20,000		15	1,333	1,333	1,999	9
10	Signage	2007		3,953		15	132	132	132	10
11	Build Garage	2007		10,880		15	363	363	363	11
12	Carpeting-Offices	2007		15,549		10	777	777	777	12
13	Blinds	2007		730		10	37	37	37	13
14	Fire Alarm System	2007		10,450		15	348	348	348	14
15	Egress Lighting	2007		4,435		15	148	148	148	15
16	Evaporator	2007		1,298		15	43	43	43	16
17	Tile-Therapy Room	2007		7,540		15	251	251	251	17
18										18
19										19
20										20
21										21
22	Building Booked				99,072			(99,072)		22
23	Land Improvements Booked				1,333			(1,333)		23
24	Building Improvements Booked				4,789			(4,789)		24
25										25
26										26
27										27
28										28
29										29
30	2007-Home Office Allocation-Land Improvements			928			55	55		30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,559,639	\$ 105,194		\$ 86,159	\$ (19,035)	\$ 127,598	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 411,171	\$ 58,739	\$ 41,117	\$ (17,622)	10	\$ 61,676	71
72	Current Year Purchases	8,981	871	449	(422)	10	449	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,486	2,486			74
75	TOTALS	\$ 420,152	\$ 59,610	\$ 44,052	\$ (15,558)		\$ 62,125	75

D. Vehicle Depreciation (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	\$ 907	\$ 2,720	\$ 1,813	5	\$ 2,720	76
77										77
78										78
79										79
80	TOTALS			\$ 27,198	\$ 907	\$ 2,720	\$ 1,813		\$ 2,720	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)	\$ 3,116,989	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,931	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,780)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 192,443	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

**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		<u>Home Office Allocation</u>			<u>50</u>			6
7	TOTAL				\$ <u>50</u>			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: \$ 8,269 Description: See 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			<u>N/A</u>		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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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

0048553

Period Beginning 01/01/2007

Period End 12/31/2007

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Dishwasher	700
Maintenance Equipment	35
Medical Equipment	6,878
Home Office Allocation	656
	<u>8,269</u>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	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	L. 10A, C. 3	hrs	\$	5,812	\$ 87,180	\$	5,812	\$ 87,180	1
2	Licensed Speech and Language Development Therapist	L. 10A, C. 3	hrs		3,262	48,925		3,262	48,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 1,2,3	625 hrs	15,179	8,119	121,791	1,117	8,744	138,087	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				71,150		71,150	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	L. 10A, C. 3			2	25		2	25	13
14	<b>TOTAL</b>			\$ 15,179	17,195	\$ 257,921	\$ 72,267	17,820	\$ 345,367	14

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

Facility Name &amp; ID Number Willow Rose Rehab &amp; Health

# 0048553

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (51,914)	\$ (51,914)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u> )	387,611	387,611	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,470	14,470	6
7	Other Prepaid Expenses	27,216	27,216	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 377,383	\$ 377,383	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		110,000	13
14	Buildings, at Historical Cost	2,610,880	2,484,804	14
15	Leasehold Improvements, at Historical Cost	43,954	74,835	15
16	Equipment, at Historical Cost	447,350	447,350	16
17	Accumulated Depreciation (book methods)	(188,200)	(192,443)	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 (spec <u>Loan Costs</u> )	29,242	29,242	22
23	Other(specify): <u>Due from Prior Owner</u>	29,022	29,022	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,972,248	\$ 2,982,810	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,349,631	\$ 3,360,193	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 353,904	\$ 353,904	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,183	50,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,350	3,350	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000	39,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	19,042	19,042	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 465,479	\$ 465,479	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	26,821	26,821	39
40	Mortgage Payable	2,391,432	2,391,432	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,418,253	\$ 2,418,253	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,883,732	\$ 2,883,732	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 465,899	\$ 476,461	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,349,631	\$ 3,360,193	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	366,229	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>R/E as of 1/1/07-Not Required to Prev Rpt</b>	99,670	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 465,899	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 465,899	<b>24</b> *

\* This must agree with page 17, line 47.

**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

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,561,145	1
2	Discounts and Allowances for all Levels	26,289	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,587,434	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	404,507	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 404,507	8
	<b>C. Other Operating Revenue</b>		
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	4,400	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,103	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	35,066	20
21	Other Medical Services	13,824	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 155,393	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous Revenue</u>	188	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 188	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,147,522	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	610,414	31
32	Health Care	1,186,165	32
33	General Administration	365,688	33
	<b>B. Capital Expense</b>		
34	Ownership	433,151	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	141,187	35
36	Provider Participation Fee	44,688	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,781,293	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	366,229	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 366,229	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Willow Rose Rehab & Health

# 0048553

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	2,048	2,048	\$ 42,245	\$ 20.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,448	6,480	136,414	21.05	3
4	Licensed Practical Nurses	11,092	11,450	183,544	16.03	4
5	CNAs & Orderlies	42,530	43,074	390,546	9.07	5
6	CNA Trainees					6
7	Licensed Therapist	625	625	15,179	24.29	7
8	Rehab/Therapy Aides	3,029	3,096	29,702	9.59	8
9	Activity Director	1,825	1,978	18,327	9.27	9
10	Activity Assistants					10
11	Social Service Workers	1,873	1,937	16,975	8.76	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,140	10.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,843	12,994	94,397	7.26	15
16	Dishwashers					16
17	Maintenance Workers	2,037	2,085	23,562	11.30	17
18	Housekeepers	11,150	11,281	86,176	7.64	18
19	Laundry	5,523	5,583	47,079	8.43	19
20	Administrator	2,080	2,080	51,000	24.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,721	3,825	42,545	11.12	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 C: Care Plan Coord	2,080	2,080	33,531	16.12	32
33	Other(specify) <u>Marketing</u>	1,784	1,900	17,391	9.15	33
34	TOTAL (lines 1 - 33)	112,768	114,596	\$ 1,250,753 *	\$ 10.91	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	Monthly	\$ 3,724	L. 1, C. 3	35
36	Medical Director	Monthly	9,000	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,824		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53



Willow Rose Rehab & Health  
 0048553  
 Period Beginning 01/01/2007  
 Period End 12/31/2007

**Schedule 21A**

**XIX. SUPPORT SCHEDULE  
 C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		4,262

Non-allowable legal expense

**Home Office Allocation**

**Petersen Health Care, Inc**

Pearl & Associates	Legal	27
Addy Bush & Assoc	Legal	14
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	61
Duane Morris	Legal	95
Ginoli & Co.	Accountants	962
RSM McGladrey	Accountants	167
McGladrey & Pullen	Accountants	254
Emdeon Business Services	Computer Services	66
Advanced Answers on Demand	Computer Services	1,785
Access 2 Go	Computer Services	135
Ivans	Computer Services	118
Kemper Technology	Computer Services	280
Adminastar Federal	Computer Services	35
Logmeln	Computer Services	22
E-Health Data Solutions	Computer Services	175
Miscellaneous Vendors	Miscellaneous	11

**Petersen Companies, LLC**

Miscellaneous Vendors	Legal	69
Ginoli & Co.	Accountants	589
McGladrey & Pullen	Accountants	812

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>9,941</u>
--	--------------



Facility Name &amp; ID Number Willow Rose Rehab &amp; Health

# 0048553

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,410 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 44,688  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,400
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? N/A
- 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**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees