

Facility Name & ID Number Willow Rose Rehab & Health

0050633 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	14,549	2,731	992	18,272	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,549	2,731	992	18,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.08%

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

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 12/7/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/7/2006 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 952

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	111,036	8,372	1,061	120,469		120,469	797	121,266		1
2	Food Purchase		113,736		113,736		113,736	77	113,813		2
3	Housekeeping	90,056	20,164		110,220		110,220	36	110,256		3
4	Laundry	39,031	8,690		47,721		47,721		47,721		4
5	Heat and Other Utilities			96,050	96,050		96,050	273	96,323		5
6	Maintenance	30,639	7,541	20,916	59,096		59,096	1,764	60,860		6
7	Other (specify):* Home Off. Ben. All.							204	204		7
8	TOTAL General Services	270,762	158,503	118,027	547,292		547,292	3,151	550,443		8
	B. Health Care and Programs										
9	Medical Director			8,100	8,100		8,100		8,100		9
10	Nursing and Medical Records	806,700	47,828	4,446	858,974		858,974	(1,939)	857,035		10
10a	Therapy			141,142	141,142		141,142		141,142		10a
11	Activities	38,601	164	785	39,550		39,550	(14,601)	24,949		11
12	Social Services	20,105			20,105		20,105		20,105		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	865,406	47,992	154,473	1,067,871		1,067,871	(16,540)	1,051,331		16
	C. General Administration										
17	Administrative			219,900	219,900		219,900	(142,881)	77,019		17
18	Directors Fees										18
19	Professional Services			2,986	2,986		2,986	12,820	15,806		19
20	Dues, Fees, Subscriptions & Promotions			3,406	3,406		3,406	409	3,815		20
21	Clerical & General Office Expenses	25,836	3,385	5,707	34,928		34,928	49,475	84,403		21
22	Employee Benefits & Payroll Taxes			197,382	197,382		197,382		197,382		22
23	Inservice Training & Education							72	72		23
24	Travel and Seminar			95	95		95	4	99		24
25	Other Admin. Staff Transportation			6,024	6,024		6,024	3,333	9,357		25
26	Insurance-Prop.Liab.Malpractice			36,864	36,864		36,864	644	37,508		26
27	Other (specify):* Home Off. Ben. All.							4,130	4,130		27
28	TOTAL General Administration	25,836	3,385	472,364	501,585		501,585	(71,994)	429,591		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,162,004	209,880	744,864	2,116,748		2,116,748	(85,383)	2,031,365		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 & ID Number

Willow Rose Rehab & Health

#0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			161,501	161,501		161,501	(22,386)	139,115			30
31	Amortization of Pre-Op. & Org.			12,607	12,607		12,607		12,607			31
32	Interest			222,330	222,330		222,330	89,656	311,986			32
33	Real Estate Taxes			47,030	47,030		47,030	290	47,320			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,635	13,635		13,635	700	14,335			35
36	Other (specify):*											36
37	TOTAL Ownership			457,103	457,103		457,103	68,260	525,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	107	41,760		41,867		41,867		41,867			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,959	159,959		159,959		159,959			42
43	Other (specify):* Non-allowable Costs		240	51,047	51,287		51,287	(51,287)				43
44	TOTAL Special Cost Centers	107	42,000	211,006	253,113		253,113	(51,287)	201,826			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,162,111	251,880	1,412,973	2,826,964		2,826,964	(68,410)	2,758,554			45

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

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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	(2,804)	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	(25,526)	30		9
10	Interest and Other Investment Income	(26,470)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(140)	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	(22,423)	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	(21,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,694)	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	(22,956)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (123,013)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	54,603	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 54,603		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (68,410)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Willow Rose Rehab & Health

ID# 0050633

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,233)	43	1
2	X-Rays-Part A	(1,039)	43	2
3	Offset Transportation Revenue	(14,601)	11	3
4	Offset NonAllowable Dues	(225)	20	4
5	Offset Miscellaneous Office Supplies Revenue	(148)	21	5
6	Offset Miscellaneous Nursing Supplies Revenue	(1,952)	20	6
7	Disallowed Special Events	1	43	7
8	Disallowed Pet Expense	(1,092)	43	8
9	Disallowed Air Travel	(1,667)	43	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		(22,956)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	3,601	0	0	0	0	0	0	0	0	0	3,601	1
2	Food Purchase	0	77	0	0	0	0	0	0	0	0	0	77	2
3	Housekeeping	0	36	0	0	0	0	0	0	0	0	0	36	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	273	0	0	0	0	0	0	0	0	0	273	5
6	Maintenance	0	1,764	0	0	0	0	0	0	0	0	0	1,764	6
7	Other (specify):*	0	204	0	0	0	0	0	0	0	0	0	204	7
8	TOTAL General Services	0	5,955	0	0	0	0	0	0	0	0	0	5,955	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13	0	0	0	0	0	0	0	0	0	13	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(14,601)	0	0	0	0	0	0	0	0	0	0	(14,601)	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	(14,601)	13	0	0	0	0	0	0	0	0	0	(14,588)	16
	C. General Administration													
17	Administrative	0	(142,881)	0	0	0	0	0	0	0	0	0	(142,881)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,591	0	0	0	0	0	0	0	0	0	7,591	19
20	Fees, Subscriptions & Promotions	(2,177)	0	483	5,229	0	0	0	0	0	0	0	3,535	20
21	Clerical & General Office Expenses	(148)	0	44,622	151	0	0	0	0	0	0	0	44,625	21
22	Employee Benefits & Payroll Taxes	0	0	0	5,001	0	0	0	0	0	0	0	5,001	22
23	Inservice Training & Education	0	0	72	0	0	0	0	0	0	0	0	72	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,333	0	0	0	0	0	0	0	0	3,333	25
26	Insurance-Prop.Liab.Malpractice	0	0	644	0	0	0	0	0	0	0	0	644	26
27	Other (specify):*	0	0	4,130	0	0	0	0	0	0	0	0	4,130	27
28	TOTAL General Administration	(2,325)	(135,290)	53,288	10,381	0	(73,946)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,926)	(129,322)	53,288	10,381	0	(82,579)	29						

STATE OF ILLINOIS

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	2,958	182	0	0	0	0	0	0	0	3,140	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,921	111,205	0	0	0	0	0	0	0	116,126	32
33	Real Estate Taxes	0	0	290	0	0	0	0	0	0	0	0	290	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	533	167	0	0	0	0	0	0	0	700	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	8,702	111,554	0	120,256	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):*	(31,556)	0	0	0	0	0	0	0	0	0	0	(31,556)	43
44	TOTAL Special Cost Centers	(31,556)	0	0	0	0	0	0	0	0	0	0	(31,556)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(48,482)	(129,322)	61,990	121,935	0	0	0	0	0	0	0	6,121	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, Inc.	100.00%	\$ 3,601	\$ 3,601	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	77	77	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	273	273	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,764	1,764	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	204	204	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13	13	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%	0		10
11	V	17 Administrative	219,900	Petersen Health Care, Inc.	100.00%	77,019	(142,881)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,591	7,591	12
13	V							13
14	Total		\$ 219,900			\$ 90,578	\$ * (129,322)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 483	\$	483	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	44,622		44,622	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	72		72	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4		4	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,333		3,333	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	644		644	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,130		4,130	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,958		2,958	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,921		4,921	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	290		290	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	533		533	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		\$			\$ 61,990	\$ *	61,990	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: 1/1/2013

Ending: 12/31/2013

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	12 Social Services		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%	0		25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	5,229	5,229	26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	151	151	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	5,001	5,001	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	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%	182	182	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	111,205	111,205	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%	167	167	38	
39	Total		\$			\$ 121,935	\$ *	121,935	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:

1/1/2013

Ending:

12/31/2013

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 J	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 Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				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:

1/1/2013

Ending:

12/31/2013

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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										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:

1/1/2013

Ending: 2/31/2013

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	1,560,986	75	\$ 307,592	\$ 295,212	18,272	\$ 3,601	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	18,272	77	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	18,272	36	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	18,272	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	18,272	273	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	18,272	1,764	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	18,272	204	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	18,272	13	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	18,272	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	18,272	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	18,272	77,019	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	18,272	7,591	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	18,272	483	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	18,272	44,622	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	18,272	72	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	18,272	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	18,272	3,333	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	18,272	644	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	18,272	4,130	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	18,272	2,958	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	18,272	4,921	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	18,272	290	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	18,272	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	18,272	533	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 152,568	25

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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 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

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	200,356	12		18,272		1
2	2	Food	Resident Days	200,356	12		18,272		2
3	3	Housekeeping	Resident Days	200,356	12		18,272		3
4	4	Laundry	Resident Days	200,356	12		18,272		4
5	5	Utilities	Resident Days	200,356	12		18,272		5
6	6	Maintenance	Resident Days	200,356	12		18,272		6
7	7	Mgmt. Allocation of Benefits	Resident Days	200,356	12		18,272		7
8	10	Nursing and Medical Records	Resident Days	200,356	12		18,272		8
9	12	Social Services	Resident Days	200,356	12		18,272		9
10	17	Administrative	Resident Days	200,356	12		18,272		10
11	19	Professional Services	Resident Days	200,356	12		18,272		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	200,356	12	57,335	18,272	5,229	12
13	21	Clerical and General Office	Resident Days	200,356	12	1,657	18,272	151	13
14	22	Employee Benefits & Payroll	Resident Days	200,356	12	54,836	18,272	5,001	14
15	23	Inservice Training & Education	Resident Days	200,356	12	(1)	18,272		15
16	24	Travel and Seminar	Resident Days	200,356	12		18,272		16
17	25	Other Admin. Staff Transport.	Resident Days	200,356	12		18,272		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	200,356	12		18,272		18
19	27	Mgmt. Allocation of Benefits	Resident Days	200,356	12		18,272		19
20	30	Depreciation	Resident Days	200,356	12	2,000	18,272	182	20
21	32	Interest	Resident Days	200,356	12	1,219,384	18,272	111,205	21
22	33	Real Estate Taxes	Resident Days	200,356	12		18,272		22
23	34	Rent-Facility and Grounds	Resident Days	200,356	12		18,272		23
24	35	Rent-Equipment & Vehicles	Resident Days	200,356	12	1,832	18,272	167	24
25	TOTALS					\$ 1,337,043	\$	\$ 121,935	25

Facility Name & ID Number

Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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**					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	The Private Bank		X	Mortgage	Varies	11/1/09	3,245,114	\$ 3,013,095	10/31/14	Varies	\$ 222,330	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 3,245,114	\$ 3,013,095			\$ 222,330	9					
	B. Non-Facility Related*																
10												10					
11										Interest Income Offset	(26,470)	11					
12										Home Office Allocation-PHC	4,921	12					
13										Home Office Allocation-PHN	111,205	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 89,656	14					
15	TOTALS (line 9+line14)						\$ 3,245,114	\$ 3,013,095			\$ 311,986	15					

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.			\$ 43,836	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012		\$ 44,762	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ 926	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 46,104	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$	For	Tax Year.			
			Home Office Allocation 290	6	
			\$		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 47,320	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	39,102	8		
	2009	40,659	9		
	2010	41,591	10		
	2011	42,563	11		
	2012	44,762	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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: 12,607 2. Number of Years Over Which it is Being Amortized: 1
 3. Current Period Amortization: 12,607 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>153,475</u>	<u>2006</u>	<u>\$ 110,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>153,475</u>		<u>\$ 110,000</u>	<u>3</u>

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	\$ 2,470,000	\$	30	\$ 82,333	\$ 82,333	\$ 535,165	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements	2006		20,000		15	1,333	1,333	9,997	9
10	Signage	2007		3,953		15	264	264	1,716	10
11	Build Garage	2007		10,880		15	725	725	4,713	11
12	Carpeting-Offices	2007		15,549		10	1,555	1,555	10,107	12
13	Blinds	2007		730		10	73	73	475	13
14	Fire Alarm System	2007		7,750		15	517	517	3,630	14
15	Egress Lighting	2007		4,435		15	296	296	1,924	15
16	Evaporator	2007		1,298		15	87	87	565	16
17	Tile-Therapy Room	2007		7,539		15	503	503	3,269	17
18	Water Heater	2009		6,300		5	1,260	1,260	5,670	18
19	Concrete in Parking Lot	2010		7,500		15	500	500	1,750	19
20	A/C Unit	2011		7,417		15	494	494	1,235	20
21	Smoke Detector Installation	2012		5,805		15	388	388	582	21
22	Carpeting-Dining Room and Main Floor	2013		25,519		15	851	851	851	22
23	Sprinkler System Replacement	2013		60,900		25	1,218	1,218	1,218	23
24	Water Heater	2013		3,656		7	261	261	261	24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,833			(1,833)		30
31	Building Booked				99,235			(99,235)		31
32	Building Improvement Booked				9,192			(9,192)		32
33										33
34	2013-Home Office Allocation-Building Improvements			8,592			206	206		34
35	2013-Home Office Allocation-Land Improvements			802			51	51		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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,668,625	\$ 110,260		\$ 92,915	\$ (17,345)	\$ 583,128	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	\$ 431,631	\$ 51,058	\$ 43,163	\$ (7,895)	5-10 yrs.	\$ 320,529	71
72	Current Year Purchases	3,076	183	154	(29)	10 yrs.	154	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,883	2,883			74
75	TOTALS	\$ 434,707	\$ 51,241	\$ 46,200	\$ (5,041)		\$ 320,683	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)	\$ 3,240,530	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,501	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,115	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,386)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 931,009	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.

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 14,335 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Willow Rose Rehab & Health

0050633

Period Beginning 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	9,284
Dishwasher		712
Laundry Equipment		-
Copier		3,639
Home Office Allocation		700
		<u>14,335</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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,947	\$ 59,208	\$	3,947	\$ 59,208	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,853	27,794		1,853	27,794	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3), 39(1)	8 hrs	107	3,609	54,140		3,617	54,247	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				41,760		41,760	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			\$ 107	9,409	\$ 141,142	\$ 41,760	9,417	\$ 183,009	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 & ID Number Willow Rose Rehab & Health# 0050633Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,855,866	\$ 1,855,866	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>144,390</u>)	418,264	418,264	3
4	Supply Inventory (priced at)	11,567	11,567	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,345	34,345	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,320,042	\$ 2,320,042	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	2,478,592	14
15	Leasehold Improvements, at Historical Cost	150,852	190,033	15
16	Equipment, at Historical Cost	461,905	461,905	16
17	Accumulated Depreciation (book methods)	(1,221,412)	(931,009)	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): <u>A/R Prior Owner</u>	264	264	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,009,989	\$ 2,309,785	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,330,031	\$ 4,629,827	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 374,810	\$ 374,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,558	64,558	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,650	5,650	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,104	46,104	32
33	Accrued Interest Payable	18,723	18,723	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	15,126	15,126	36
37	<u>Accrued Management Fees</u>	106,340	106,340	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 631,311	\$ 631,311	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,013,095	3,013,095	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	365,175	365,175	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,378,270	\$ 3,378,270	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,009,581	\$ 4,009,581	46
47	TOTAL EQUITY(page 18, line 24)	\$ 320,450	\$ 620,246	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,330,031	\$ 4,629,827	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 581,933	1
2	Restatements (describe):		2
3	Nursing Supply Expense Entered after CR was completed	(898)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 581,035	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(260,585)	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)	\$ (260,585)	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)	\$ 320,450	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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	\$ 2,335,674	1
2	Discounts and Allowances for all Levels	(109,165)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,226,509	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	220,277	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 220,277	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	2,804	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,488	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,527	20
21	Other Medical Services	2,603	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76,422	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26,470	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,470	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,100	28
28a	Transportation Revenue	14,601	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,701	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,566,379	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	547,292	31
32	Health Care	1,067,871	32
33	General Administration	501,585	33
B. Capital Expense			
34	Ownership	457,103	34
C. Ancillary Expense			
35	Special Cost Centers	93,154	35
36	Provider Participation Fee	159,959	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,826,964	40
41	Income before Income Taxes (line 30 minus line 40)**	(260,585)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (260,585)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,737,079	44
45	Private Pay - Net Inpatient Revenue	290,410	45
46	Medicare - Net Inpatient Revenue	200,152	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(1,132)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,226,509	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,884	1,884	\$ 53,180	\$ 28.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,918	7,328	161,883	22.09	3
4	Licensed Practical Nurses	8,611	9,015	162,785	18.06	4
5	CNAs & Orderlies	35,772	37,439	364,866	9.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,821	1,980	23,671	11.96	8
9	Activity Director	1,794	1,970	21,375	10.85	9
10	Activity Assistants					10
11	Social Service Workers	1,761	1,945	20,105	10.34	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,140	12.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,057	9,524	84,896	8.91	15
16	Dishwashers					16
17	Maintenance Workers	1,926	2,191	30,639	13.98	17
18	Housekeepers	9,418	9,712	90,056	9.27	18
19	Laundry	4,380	4,439	39,031	8.79	19
20	Administrator	2,080	2,080	77,019	37.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	25,836	12.42	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: CPC	2,088	2,088	40,422	19.36	32
33	Other(specify) <u>Transportation</u>	1,600	1,637	17,226	10.52	33
34	TOTAL (lines 1 - 33)	93,270	97,392	\$ 1,239,130 *	\$ 12.72	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	21	\$ 1,061	L1, C3	35
36	Medical Director	Monthly	8,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,684	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	110	L10, 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)	23	\$ 12,955		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

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	
Suzanne Boston	Administrator	0	\$ 77,019	Workers' Compensation Insurance	\$ 67,594	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	36,318	Advertising: Employee Recruitment	106	
				FICA Taxes	88,754	Health Care Worker Background Check		
				Employee Health Insurance	(7,682)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	(1,255)	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	350	
				Employee Relations	12,398	Miscellaneous Dues & Subscriptions	225	
						Home Office Allocation	634	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 77,019					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 219,900				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 219,900				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount			\$ 197,382		\$ 3,815
E-Health Data Solutions	Computer Services		\$ 2,025					
Grafton Technologies	Computer Services		1,257					
Mark Brueggerman	Legal Services		125					
Brown & James	Legal Services		79					
Miscellaneous Vendors	Reversal of 2012 Invoices		(500)					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 2,986					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Willow Rose Rehab & Health
0050633
Period Beginning
Period End

1/1/2013
12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,986
Home Office Allocation		
SmithAmundsen	Legal	451
Cole, Schotz, Meisel	Legal	594
Black, Hedin, Ballard	Legal	22
Ginoli & Company	Accountants	822
RSM McGladrey	Accountants	2079
Miscellaneous	Computer Services	72
Odessian LLC	Computer Services	35
CCH	Computer Services	10
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	9
Macquarie Technology Services	Computer Services	64
Advanced Answers on Demand	Computer Services	3341
TeamViewer	Computer Services	11
Stratus Networks	Computer Services	269
Kemper Technology	Computer Services	208
AT&T	Computer Services	4
Medifax	Computer Services	30
Vision Share/Ability Network	Computer Services	458
Barracuda	Computer Services	82
CIAN	Computer Services	110
Comcast	Computer Services	24
Emdeon	Computer Services	37
Marotta Gund Budd & Dzera	Other Prof Fees	1023
David Budde	Other Prof Fees	21
Pharmacy Price Mangement	Other Prof Fees	85

All Scripts	Other Prof Fees	2499
Red Ridge Financial Group	Other Prof Fees	456
Total (agree to Schedule V, line 19, column 8)		<u>15,806</u>

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

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

Facility Name & ID Number Willow Rose Rehab & Health

0050633

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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. _____
- (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. \$ 11,285 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. \$ 159,959
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. \$ 2,804
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 14,601
- 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Willow Rose Rehab & H

10:19 AM 5/21/2014

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-68,410	equal to	-68,410	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	311,986	equal to	311,986	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	47,320	equal to	47,320	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	12,607	equal to	12,607	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	139,115	equal to	139,115	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	14,335	equal to	14,335	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	107	equal to	107	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	141,142	equal to	141,142	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	41,760	equal to	41,760	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	547,292	equal to	547,292	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,067,871	equal to	1,067,871	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	501,585	equal to	501,585	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	457,103	equal to	457,103	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	93,154	equal to	93,154	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	159,959	equal to	159,959	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	806,807	equal to	806,700	107	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	107	equal to	107	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	38,601	equal to	38,601	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,105	equal to	20,105	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	111,036	equal to	111,036	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	30,639	equal to	30,639	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	90,056	equal to	90,056	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	39,031	equal to	39,031	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	77,019	equal to	77,019	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	25,836	equal to	25,836	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,239,130	equal to	1,162,111	77,019	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,061	< or = to	1,061	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	8,100	< or = to	8,100	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,794	< or = to	4,446	-652	O.K.	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	785	-785	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	77,019	equal to	77,019	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	219,900	equal to	219,900	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	2,986	equal to	2,986	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	197,382	equal to	197,382	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,815	equal to	3,815	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	99	equal to	99	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	159,959	equal to	159,959	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	952	equal to	992	-40	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	54,603	equal to	54,603	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4l	B.	14	8
Total loan balance	3,013,095	equal to	3,013,095	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	46,104	equal to	46,104	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	110,000	equal to	110,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,668,625	equal to	2,668,625	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	461,905	equal to	461,905	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	931,009	equal to	931,009	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	320,450	equal to	320,450	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-260,585	equal to	-260,585	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31...f	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,330,031	equal to	4,330,031	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	111,036	8,372	1,061	120,469	0	120,469	797	121,266
2. Food Purchase	0	113,736	0	113,736	0	113,736	77	113,813
3. Housekeeping	90,056	20,164	0	110,220	0	110,220	36	110,256
4. Laundry	39,031	8,690	0	47,721	0	47,721	0	47,721
5. Heat and Other Utilities	0	0	96,050	96,050	0	96,050	273	96,323
6. Maintenance	30,639	7,541	20,916	59,096	0	59,096	1,764	60,860
7. Other (specify)*	0	0	0	0	0	0	204	204
8. Total General Services	270,762	158,503	118,027	547,292	0	547,292	3,151	550,443
9. Medical Director	0	0	8,100	8,100	0	8,100	0	8,100
10. Nursing & Medical Records	806,700	47,828	4,446	858,974	0	858,974	-1,939	857,035
10a. Therapy	0	0	141,142	141,142	0	141,142	0	141,142
11. Activities	38,601	164	785	39,550	0	39,550	-14,601	24,949
12. Social Services	20,105	0	0	20,105	0	20,105	0	20,105
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	865,406	47,992	154,473	1,067,871	0	1,067,871	-16,540	1,051,331
17. Administrative	0	0	219,900	219,900	0	219,900	-142,881	77,019
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,986	2,986	0	2,986	12,820	15,806
20. Fees, Subscriptions & Promotion	0	0	3,406	3,406	0	3,406	409	3,815
21. Clerical & General Office	25,836	3,385	5,707	34,928	0	34,928	49,475	84,403
22. Employee Benefits & Payroll	0	0	197,382	197,382	0	197,382	0	197,382
23. Inservice Training & Education	0	0	0	0	0	0	72	72
24. Travel and Seminar	0	0	95	95	0	95	4	99
25. Other Admin. Staff Trans	0	0	6,024	6,024	0	6,024	3,333	9,357
26. Insurance-Prop.Liab.Malpractice	0	0	36,864	36,864	0	36,864	644	37,508
27. Other (specify)*	0	0	0	0	0	0	4,130	4,130
28. Total General Adminis	25,836	3,385	472,364	501,585	0	501,585	-71,994	429,591
29. Total General Administrative	1,162,004	209,880	744,864	2,116,748	0	2,116,748	-85,383	2,031,365
30. Depreciation	0	0	161,501	161,501	0	161,501	-22,386	139,115
31. Amortization of Pre-Op. & Org.	0	0	12,607	12,607	0	12,607	0	12,607
32. Interest	0	0	222,330	222,330	0	222,330	89,656	311,986
33. Real Estate	0	0	47,030	47,030	0	47,030	290	47,320

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	13,635	13,635	0	13,635	700	14,335
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	457,103	457,103	0	457,103	68,260	525,363
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	107	41,760	0	41,867	0	41,867	0	41,867
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	0	159,959	159,959	0	159,959	0	159,959
43. Other (specify):*	0	240	51,047	51,287	0	51,287	-51,287	0
44. Total Special Cost Ce	107	42,000	211,006	253,113	0	253,113	-51,287	201,826
45. Grand Total	1,162,111	251,880	1,412,973	2,826,964	0	2,826,964	-68,410	2,758,554

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,855,866	1,855,866
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	418,264	418,264
4. Supply Inventory	11,567	11,567
5. Short-Term Investments	0	0
6. Prepaid Insurance	34,345	34,345
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	-365,175	-365,175
9. Other (specify):	0	0
10. Total current assets	1,954,867	1,954,867
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	2,478,592
15. Leasehold Improvements, Historical Cost	150,852	190,033
16. Equipment, at Historical Cost	461,905	461,905
17. Accumulated Depreciation (book methods)	-1,221,412	-931,009
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	2,009,725	2,309,521
25. Total Assets	3,964,592	4,264,388
CURRENT LIABILITIES		
26. Accounts Payable	374,810	374,810
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	64,558	64,558
31. Accrued Taxes Payable	5,650	5,650
32. Accrued Real Estate Taxes	46,104	46,104
33. Accrued Interest Payable	18,723	18,723
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	15,126	15,126

37. Other Current Liabilities (specify):	106,340	106,340
38. Total Current Liabilities	631,311	631,311
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,013,095	3,013,095
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	-264	-264
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,012,831	3,012,831
46.Total Liabilities	3,644,142	3,644,142
47.Total Equity	320,450	620,246
48.Total Liabilities and Equity	3,964,592	4,264,388

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,335,674
2. Discounts and Allowances for all Levels	-109,165
Subtotal - Inpatient Care	2,226,509
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	220,277
7. Oxygen	0
Subtotal - Anciliary Revenue	220,277
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	2,804
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	67,488
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	3,527
21. Other Medical Services	2,603
22. Laundry	0
Subtotal - Other Operating Revenue	76,422
24. Contributions	0
25. Interest and Other Investments Income	26,470
Subtotal - Non-Operating Revenue	26,470
27. Other Revenue (specify):	0
28. Other Revenue (specify):	16,701
Subtotal - Other Revenue	16,701
30. Total Revenue	2,566,379
31. General Services	526,795
32. Health Care	1,145,715
33. General Administration	591,233
34. Ownership	444,495

35. Special Cost Centers	80,783
35. Provider Participation Fee	256,777
37. Other	0
40. Total Expenses	3,045,798
41. Income Before Income Taxes	-479,419
42. Income Taxes	0
43. Net Income or Loss for the Year	-479,419

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!

5/21/2014 10:19:33 AM

HSA Number: _____ 3 Name: Willow Rose Rehab & Health

Cost report period From: 1/1/2013 To: 12/31/2013 Base Number: 456

If this is an ICF/DD 16 facility, enter a 1 in cell C6

Licensed bed days: 35,770 Occupancy: N 18,272 Pct. of occupancy: 51.08%

Illinois Public Aid Support Rate: \$ _____

Genl Services Salary/Wage: 270,762 Col 1, Line 8 ---Audit Adj: _____

Genl Admin Salary/Wage: 25,836 Col 1, Line 28 ---Audit Adj: _____

Total Salary Wage: 1,162,111 Col 1, Line 44 ---Audit Adj: _____

Employee Benefits: 197,382 Col 8, Line 22 ---Audit Adj: _____

Total General Services: 550,443 Col 8, Line 8 ---Audit Adj: _____

Total General Admin: 429,591 Col 8, Line 28 ---Audit Adj: _____

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

- 1 Determine the proportion of general services wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.
- 3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

- 1 Determine the proportion of General Administration wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.
- 3 Add the proportioned fringe amount to your total General Administration expenses.
- 4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Employee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 226 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupancy

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is

35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$270,762
\$1,162,111
 23.2992%
\$197,382

 \$45,988
\$550,443
\$596,431

\$25,836
\$1,162,111
 2.2232%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF)
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$197,382
\$4,388
\$429,591
\$197,382
\$236,597

6.5
0.526315789
1356

1363.026316
907.00

456

1
1

\$596,431
1

\$596,431

\$236,597
1
\$236,597
\$833,028

\$35.80

\$833,028
18,272
\$45.59

35,770
0.93
33,266
18,272
14,994
4,998
18,272
23,270

\$833,028
23270

\$35.80

\$41.84
\$35.80
\$6.04

0.5
\$3.02

\$35.80

38.82

\$41.84
\$35.80
\$6.04

0.5

\$3.02

3.635

\$3.020

\$35.80

\$38.82

\$38.82

\$41.84

\$34.67

7/DD 16 Facilities)

Centiles by HSA

Not updated with current figures

<u>75th Percentile</u>	<u>35th Percentile</u>	<u>Below 35th Profit Ceiling</u>
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655