

		FOR BHF USE					

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**2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)**

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

<p>I. IDPH License ID Number: <u>0050633</u></p> <p>Facility Name: <u>Willow Rose Rehab Health</u></p> <p>Address: <u>410 Fletcher</u> <u>Jerseyville</u> <u>62052</u> <small>Number City Zip Code</small></p> <p>County: <u>Jersey</u></p> <p>Telephone Number: <u>(618) 498-6427</u> Fax # <u>(618) 639-3339</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/7/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Mark Petersen</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Mark Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u> Fax # <u>()</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number Willow Rose Rehab Health

0050633 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	13,393	878	1,279	15,550	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,393	878	1,279	15,550	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.47%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 1,243

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Willow Rose Rehab Health # 0050633 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	131,807	14,764	4,436	151,007		151,007	4,140	155,147		1
2	Food Purchase		128,362		128,362		128,362	(493)	127,869		2
3	Housekeeping	111,219	16,604		127,823		127,823	80	127,903		3
4	Laundry	5,053	8,123		13,176		13,176		13,176		4
5	Heat and Other Utilities			96,772	96,772		96,772	283	97,055		5
6	Maintenance	23,244	4,857	27,469	55,570		55,570	2,487	58,057		6
7	Other (specify):*										7
8	TOTAL General Services	271,323	172,710	128,677	572,710		572,710	6,497	579,207		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	737,672	81,572	330,199	1,149,443		1,149,443	5,247	1,154,690		10
10a	Therapy			183,148	183,148		183,148		183,148		10a
11	Activities	54,989	(84)	22	54,927		54,927	1,444	56,371		11
12	Social Services	29,255			29,255		29,255		29,255		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	821,916	81,488	522,369	1,425,773		1,425,773	6,691	1,432,464		16
	C. General Administration										
17	Administrative	62,004		146,900	208,904		208,904	(123,873)	85,031		17
18	Directors Fees										18
19	Professional Services			7,787	7,787		7,787	13,601	21,388		19
20	Dues, Fees, Subscriptions & Promotions			1,603	1,603		1,603	1,895	3,498		20
21	Clerical & General Office Expenses	28,442	1,665	16,029	46,136		46,136	27,453	73,589		21
22	Employee Benefits & Payroll Taxes			139,421	139,421		139,421	7,048	146,469		22
23	Inservice Training & Education							43	43		23
24	Travel and Seminar							13	13		24
25	Other Admin. Staff Transportation			5,311	5,311		5,311	2,966	8,277		25
26	Insurance-Prop.Liab.Malpractice			54,458	54,458		54,458	452	54,910		26
27	Other (specify):*										27
28	TOTAL General Administration	90,446	1,665	371,509	463,620		463,620	(70,402)	393,218		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,183,685	255,863	1,022,555	2,462,103		2,462,103	(57,214)	2,404,889		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:

1/1/2020

Ending:

12/31/2020

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			121,026	121,026		121,026	(12,075)	108,951			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							146	146			32
33	Real Estate Taxes			52,588	52,588		52,588	163	52,751			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,811	35,811		35,811	1,503	37,314			35
36	Other (specify):*											36
37	TOTAL Ownership			209,425	209,425		209,425	(10,263)	199,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,050		19,050		19,050		19,050			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			140,534	140,534		140,534		140,534			42
43	Other (specify):*	16,216	100	50,542	66,858		66,858	(66,858)				43
44	TOTAL Special Cost Centers	16,216	19,150	191,076	226,442		226,442	(66,858)	159,584			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,199,901	275,013	1,423,056	2,897,970		2,897,970	(134,335)	2,763,635			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(493)	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	(16,266)	30		9
10	Interest and Other Investment Income	(58)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(14,559)	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	(31,000)	43		24
25	Fund Raising, Advertising and Promotional				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	(22,250)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (84,678)		\$	30

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)	(49,657)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (49,657)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (134,335)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

Willow Rose Rehab Health

ID# 0050633

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,325)	43	1
2	X-Rays-Part A	(635)	43	2
3	Offset Transportation Revenue	1,444	11	3
4	Disallowed Marketing Salaries Expense	(16,216)	43	4
5	Disallowed Special Events	(186)	43	5
6	Disallowed Office Supply Expense	(74)	21	6
7	Disallowed Nursing Supply Expense	(2,148)	11	7
8	Disallowed Pet Expense	(885)	43	8
9	Disallowed Chamber of Commerce Dues	(225)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,250)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,140	\$ 4,140	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	80	80	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	283	283	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,487	2,487	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,880	3,880	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	146,900	Petersen Health Care Management, Inc.	100.00%	23,027	(123,873)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	13,601	13,601	12
13	V							13
14	Total		\$ 146,900			\$ 47,498	\$ * (99,402)	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 Management, Inc.	100.00%	\$ 2,120	\$	2,120	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,673		25,673	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,048		7,048	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	43		43	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	13		13	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,966		2,966	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	452		452	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	4,191		4,191	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	204		204	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	163		163	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,503		1,503	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		\$			\$ 44,376	\$ *	44,376	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	5 Utilities		Petersen Health Network, LLC	100.00%			18
19	V	6 Maintenance		Petersen Health Network, LLC	100.00%			19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			20
21	V	9 Medical Director		Petersen Health Network, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	3,515	3,515	22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%			25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	1,854	1,854	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%			28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%			29
30	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%			30
31	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%			31
32	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			33
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	31 Amortization		Petersen Health Network, LLC	100.00%			35
36	V	32 Interest		Petersen Health Network, LLC	100.00%			36
37	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total		\$			\$ 5,369	\$ * 5,369	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:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				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: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	15,550	\$ 4,140	1
2	2	Food	Resident Days	1,282,791	75	0	0	15,550	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	15,550	80	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	15,550	283	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	15,550	2,487	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,550	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	15,550	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	15,550	3,880	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	15,550	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,550	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	15,550	23,027	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	15,550	13,601	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	15,550	2,120	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	15,550	25,673	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	15,550	7,048	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	15,550	43	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	15,550	13	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	15,550	2,966	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	15,550	452	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	15,550	4,191	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	15,550	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	15,550	204	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	15,550	163	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	15,550	1,503	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 91,874	25

Facility Name & ID Number Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	71,843	7	\$	\$	15,550	\$	1
2	2	Food	Resident Days	71,843	7			15,550		2
3	3	Housekeeping	Resident Days	71,843	7			15,550		3
4	5	Utilities	Resident Days	71,843	7			15,550		4
5	6	Maintenance	Resident Days	71,843	7			15,550		5
6	7	Mgmt. Allocation of Benefits	Resident Days	71,843	7			15,550		6
7	9	Medical Director	Resident Days	71,843	7			15,550		7
8	10	Nursing and Medical Records	Resident Days	71,843	7	16,242		15,550	3,515	8
9	10A	Therapy	Resident Days	71,843	7			15,550		9
10	15	Mgmt. Allocation of Benefits	Resident Days	71,843	7			15,550		10
11	17	Administrative	Resident Days	71,843	7			15,550		11
12	19	Professional Services	Resident Days	71,843	7	8,567		15,550	1,854	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	71,843	7			15,550		13
14	21	Clerical and General Office	Resident Days	71,843	7			15,550		14
15	22	Employee Benefits and Payroll Ta	Resident Days	71,843	7			15,550		15
16	23	Inservice Training & Education	Resident Days	71,843	7			15,550		16
17	24	Travel and Seminar	Resident Days	71,843	7			15,550		17
18	25	Other Admin. Staff Transport.	Resident Days	71,843	7			15,550		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	71,843	7			15,550		19
20	30	Depreciation	Resident Days	71,843	7			15,550		20
21	31	Amortization	Resident Days	71,843	7			15,550		21
22	32	Interest	Resident Days	71,843	7			15,550		22
23	33	Real Estate Taxes	Resident Days	71,843	7			15,550		23
24	35	Rent-Equipment & Vehicles	Resident Days	71,843	7			15,550		24
25	TOTALS					\$ 24,809	\$		\$ 5,369	25

Facility Name & ID Number

Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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		7	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			X				\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(58)	10						
11									Home Office Allocation-PHCM		204	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	146	14					
15	TOTALS (line 9+line14)						\$	\$			\$	146	15					

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

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

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

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 2019 report.		\$	50,784	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.)		\$	50,920	2
3. Under or (over) accrual (line 2 minus line 1).		\$	136	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	52,452	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. Home Office Allocation			163	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	52,751	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	50,179	8
	2016	50,327	9
	2017	50,110	10
	2018	49,307	11
	2019	50,920	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Rose Rehab & Health Care Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0050633

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>04-208-024-00</u>	<u>Long-Term Care Facility</u>	\$ <u>50,920.26</u>	\$ <u>50,920.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>50,920.26</u></u>	\$ <u><u>50,920.26</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. 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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	2006	1974	\$ 2,490,000	\$	30	\$ 83,666	\$ 83,666	\$ 1,047,158	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Signage		2007	3,953		15	264	264	3,564	9
10	Carpeting-Offices		2007	14,995		10			14,995	10
11	Fire Alarm System		2007	7,750		15	517	517	7,249	11
12	Egress Lighting		2007	4,435		15	296	296	3,996	12
13	Tile-Therapy Room		2007	5,152		15			5,152	13
14	Water Heater		2009	6,300		5			6,300	14
15	Concrete in Parking Lot		2010	7,500		15	500	500	5,250	15
16	A/C Unit		2011	7,417		15	494	494	4,693	16
17	Smoke Detector Installation		2012	5,805		15	388	388	3,298	17
18	Carpeting-Dining Room and Main Floor		2013	16,969		15	1,131	1,131	9,339	18
19	Sprinkler System Replacement		2013	60,900		25	2,436	2,436	18,270	19
20	Water Heater		2013	3,656		7	263	263	3,656	20
21	A/C Unit-Roof Top		2014	6,458		15	431	431	2,802	21
22	Water Heater		2014	2,991		7	427	427	2,776	22
23	Flooring, New Doors, Hallway Opening, Drywall Repair-Dining Room		2014	15,578		15	1,039	1,039	6,754	23
24	Exterior Building Siding Replacement		2014	35,377		25	1,415	1,415	9,198	24
25	Door Alarm System		2015	5,522		7	790	790	4,345	25
26	Tiling for 4 Shower Rooms		2015	24,800		15	1,654	1,654	9,097	26
27	Water Leak Repair		2016	3,220		7	460	460	2,070	27
28	Electrical Repair		2016	13,675		7	1,954	1,954	8,793	28
29	Flooring for Hallway		2016	3,136		10	314	314	1,413	29
30	HVAC Unit		2018	8,275		15	552	552	1,380	30
31	Drywall for Bathroom		2019	3,574		10	358	358	537	31
32	Water Line Repair		2019	3,580		7	512	512	768	32
33	Generator		2020	12,092		15	403	403	403	33
34	Plumbing Repair		2020	5,200		7	371	371	371	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 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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57			1,611			(1,611)	
58			99,235			(99,235)	
59			16,590			(16,590)	
60							
61		7,862			189	189	
62		789			50	50	
63							
64							
65							
66							
67							
68							
69							
70		\$ 2,786,961	\$ 117,436		\$ 100,874	\$ (16,562)	\$ 1,183,627

**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	\$ 21,887	\$ 2,122	\$ 2,480	\$ 358	5-10 yrs.	\$ 12,735	71
72	Current Year Purchases	23,032	1,468	1,645	177	7 yrs.	1,645	72
73	Fully Depreciated Assets	431,631					431,631	73
74	Home Office Allocation			3,952	3,952			74
75	TOTALS	\$ 476,550	\$ 3,590	\$ 8,077	\$ 4,487		\$ 446,011	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)	\$ 3,400,709	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,026	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 108,951	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,075)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,656,836	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			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: 1/1/2020

Ending: 12/31/2020

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 37,314 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 1/1/2020

Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 20,268
Dishwasher	642
Maintenance Equipment	8,435
Copier	6,466
Home Office Allocation	1,503
	<u>37,314</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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,777	\$ 101,659	\$	6,777	\$ 101,659	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,233	33,500		2,233	33,500	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,184	47,758		3,184	47,758	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 prescripts				19,050		19,050	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			15	231		15	231	12
13	Other (specify):									13
14	TOTAL			\$	12,209	\$ 183,148	\$ 19,050	12,209	\$ 202,198	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

0050633

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 420,720	\$ 420,720	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 123,370)	1,615,803	1,615,803	3
4	Supply Inventory (priced at Cost)	11,567	11,567	4
5	Short-Term Investments			5
6	Prepaid Insurance	30,383	30,383	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	4,069	4,069	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,082,542	\$ 2,082,542	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	2,497,862	14
15	Leasehold Improvements, at Historical Cost	294,308	289,099	15
16	Equipment, at Historical Cost	503,748	503,748	16
17	Accumulated Depreciation (book methods)	(2,041,723)	(1,656,836)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	24,168	24,168	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,398,881	\$ 1,768,041	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,481,423	\$ 3,850,583	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 540,621	\$ 540,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,780	59,780	30
31	Accrued Taxes Payable (excluding real estate taxes)	115,230	115,230	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,452	52,452	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	67,490	67,490	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 835,573	\$ 835,573	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Loan Payable-MCAD Advance Payment</u>	450,000	450,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 450,000	\$ 450,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,285,573	\$ 1,285,573	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,195,850	\$ 2,565,010	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,481,423	\$ 3,850,583	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,778,899	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(588,661)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,190,238	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,005,612	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,005,612	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,195,850	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Willow Rose Rehab Health

0050633

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,095,538	1
2	Discounts and Allowances for all Levels	(557,742)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,537,796	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	354,694	6
7	Oxygen	(27)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 354,667	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	493	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	34,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,427	20
21	Other Medical Services	564	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,970	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	58	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(1,444)	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	968,535	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 967,091	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,903,582	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	572,710	31
32	Health Care	1,425,773	32
33	General Administration	463,620	33
B. Capital Expense			
34	Ownership	209,425	34
C. Ancillary Expense			
35	Special Cost Centers	85,908	35
36	Provider Participation Fee	140,534	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,897,970	40
41	Income before Income Taxes (line 30 minus line 40)**	1,005,612	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,005,612	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,847,229	44
45	Private Pay - Net Inpatient Revenue	236,730	45
46	Medicare - Net Inpatient Revenue	437,501	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	7,336	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,528,796	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Willow Rose Rehab Health

0050633

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	1,299	1,299	\$ 49,769	\$ 38.31	1
2	Assistant Director of Nursing	8	8	248	31.00	2
3	Registered Nurses	1,941	1,969	69,370	35.23	3
4	Licensed Practical Nurses	9,054	9,192	229,564	24.97	4
5	CNAs & Orderlies	20,065	20,318	303,215	14.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,771	1,782	23,286	13.07	9
10	Activity Assistants					10
11	Social Service Workers	1,846	1,974	29,255	14.82	11
12	Dietician					12
13	Food Service Supervisor	1,748	1,777	28,000	15.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	351	10,052	103,807	10.33	15
16	Dishwashers					16
17	Maintenance Workers	1,468	1,484	23,244	15.66	17
18	Housekeepers	10,965	11,206	111,219	9.92	18
19	Laundry	550	571	5,053	8.85	19
20	Administrator	1,932	1,953	62,004	31.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,842	1,914	28,442	14.86	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	6,930	7,175	133,425	18.60	33
34	TOTAL (lines 1 - 33)	61,770	72,674	\$ 1,199,901 *	\$ 16.51	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	\$ 4,436	L1, C3	35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,268	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	555	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)	8	\$ 18,259		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,279	\$ 70,911	L10,C3	50
51	Licensed Practical Nurses	1,438	61,605	L10,C3	51
52	Certified Nurse Assistants/Aides	6,938	192,860	L10,C3	52
53	TOTAL (lines 50 - 52)	9,655	\$ 325,376		53

Willow Rose Rehab Health

0050633

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,145	2,145	55,101	25.69
Transportation	2,300	2,417	31,703	13.12
Restorative Aides	1,846	1,974	30,405	15.40
Marketing	639	639	16,216	25.38
TOTAL	6,930	7,175	133,425	

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		
Kelsey Mika	Administrator	0	\$ 52,147	Workers' Compensation Insurance	\$ 23,883	IDPH License Fee	\$ 1,990		
Makenzi Fee	Administrator	0	9,857	Unemployment Compensation Insurance	13,420	Advertising: Employee Recruitment	(119)		
				FICA Taxes	85,771	Health Care Worker Background Check			
				Employee Health Insurance	3,431	(Indicate # of checks performed 34)	(960)		
				Employee Meals		Patient Background Checks	2		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	467		
				Employee Relations	520	Miscellaneous Dues & Subscriptions	225		
				Home Office Allocation	7,048	Home Office Allocation	2,120		
				Administrator Benefits	12,396				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,004			Less: Public Relations Expense	(225)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,498		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 146,900						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 146,900						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Ability Network	Computer Services		\$ 6,929				Out-of-State Travel	\$	
Grafton Technologies	Computer Services		611						
Ist Mid America Credit Union	Financial Record Fees-July		247				In-State Travel		
				N/A					
							Seminar Expense		
							Home Office Allocation	13	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,787	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 13

* Attach copy of IMRF notifications

**See instructions.

Willow Rose Rehab Health

0050633

Period Beginning

1/1/2020

Period End

12/31/2020

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,787
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	239
Duane Morris	Legal	687
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	13
Miller, Hall, Triggs	Legal	41
Miscellaneous	Legal	15
SB2	Legal	124
SmithAmundsen LLC	Legal	765
Sorling Northrup	Legal	218
Illinois Secretary of State	Legal	429
CliftonLarsonAllen	Accounting	951
Ginoli & Co.	Accounting	1,753
Ability Network	Computer Services	2,441
Allscripts	Computer Services	385
AOD Matrix Care	Computer Services	4,287
AT&T	Computer Services	5
ATS	Computer Services	234
CCH	Computer Services	14
Charter Communications	Computer Services	22
Citrix Systems	Computer Services	73
Comcast	Computer Services	25
ITSavvy	Computer Services	113
Kemper Technology	Computer Services	557
Miscellaneous	Computer Services	108
Pearl Technology	Computer Services	101
Stratus Networks	Computer Services	443
TR Professional	Computer Services	9
David Budde	Other Prof Fees	10
DJ Howard and Associates	Other Prof Fees	19
Getzler Henrich & Associates	Other Prof Fees	75
LRI Consulting Services	Other Prof Fees	73
McQuellon Consulting	Other Prof Fees	46
Miscellaneous	Other Prof Fees	231
Optimizer	Other Prof Fees	40
Registered Agent Solutions	Other Prof Fees	22
RSM McGladrey	Other Prof Fees	242
SB2	Other Prof Fees	309
Sedgwick CMS	Other Prof Fees	417
Tarver Program Consultants	Other Prof Fees	58
Total (agree to Schedule V, line 19, column 8)		<u>23,388</u>

Willow Rose Rehab Health

0050633

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	4,432
Auto Repairs		752
Mileage-Travel		127
Home Office Allocation		<u>2,966</u>
		<u><u>8,277</u></u>

Facility Name & ID Number Willow Rose Rehab Health

0050633

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,301 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 140,534
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. \$ 493
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? _____
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 and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.