FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0050849

Facility Name: Roseville Rehabilitation & Health Care

Address: 145 S. Chamberlain Street (Number) Roseville (City) 61473 (Zip Code)

County: Warren

Telephone Number: (309) 426-2134 **Fax #** (309) 426-2445

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2010

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,316	6,589	1,241	20,146	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,316	6,589	1,241	20,146	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.75%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 1,160

Medicare Intermediary Palmetto

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	151,871	11,219		163,090		163,090	4,523	167,613			1
2	Food Purchase		127,641		127,641		127,641	(7,240)	120,401			2
3	Housekeeping	111,870	16,456		128,326		128,326	68	128,394			3
4	Laundry	39,088	8,996		48,084		48,084		48,084			4
5	Heat and Other Utilities			73,797	73,797		73,797	238	74,035			5
6	Maintenance	44,605	5,195	13,908	63,708		63,708	4,455	68,163			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	347,434	169,507	87,705	604,646		604,646	2,044	606,690			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	926,772	72,336	98,766	1,097,874		1,097,874	(3,003)	1,094,871			10
10a	Therapy		15	240,862	240,877		240,877		240,877			10a
11	Activities	72,178	111	377	72,666		72,666	(24,650)	48,016			11
12	Social Services	30,059			30,059		30,059		30,059			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,029,009	72,462	352,005	1,453,476		1,453,476	(27,653)	1,425,823			16
	C. General Administration											
17	Administrative			247,300	247,300		247,300	(178,393)	68,907			17
18	Directors Fees											18
19	Professional Services			62,491	62,491		62,491	(13,836)	48,655			19
20	Dues, Fees, Subscriptions & Promotions			7,562	7,562		7,562	106	7,668			20
21	Clerical & General Office Expenses	29,704	4,521	6,643	40,868		40,868	55,453	96,321			21
22	Employee Benefits & Payroll Taxes			155,776	155,776		155,776	21,894	177,670			22
23	Inservice Training & Education			160	160		160	135	295			23
24	Travel and Seminar							67	67			24
25	Other Admin. Staff Transportation			12,103	12,103		12,103	3,241	15,344			25
26	Insurance-Prop.Liab.Malpractice			2,075	2,075		2,075	46,510	48,585			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	29,704	4,521	494,110	528,335		528,335	(64,823)	463,512			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,406,147	246,490	933,820	2,586,457		2,586,457	(90,432)	2,496,025			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 Roseville Rehabilitation & Health Care #0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,129	17,129		17,129	195,745	212,874			30
31	Amortization of Pre-Op. & Org.							1,097	1,097			31
32	Interest			902	902		902	113,691	114,593			32
33	Real Estate Taxes							117,943	117,943			33
34	Rent-Facility & Grounds			593,837	593,837		593,837	(593,837)				34
35	Rent-Equipment & Vehicles			6,036	6,036		6,036	1,374	7,410			35
36	Other (specify):*											36
37	**TOTAL Ownership**			617,904	617,904		617,904	(163,987)	453,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,508		21,508		21,508		21,508			39
40	Barber and Beauty Shops	7,396		115	7,511		7,511	(115)	7,396			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,964	168,964		168,964		168,964			42
43	Other (specify):*	31,406	397	48,270	80,073		80,073	(80,073)				43
44	**TOTAL Special Cost Centers**	38,802	21,905	217,349	278,056		278,056	(80,188)	197,868			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,444,949	268,395	1,769,073	3,482,417		3,482,417	(334,607)	3,147,810			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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,259)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,479)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	37,630	30		9
10	Interest and Other Investment Income	(634)	31		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	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	(28,134)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(993)	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	(67,197)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,407)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(227,200)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227,200)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (334,607)		37

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

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

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

Roseville Rehabilitation & Health Care

ID# 0050849

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,723)	43	1
2	X-Rays-Part A	(789)	43	2
3	Resident Flowers	(180)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(3,066)	21	4
5	Offset Transportation Revenue	(24,650)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(7)	10	6
7	Special Events	(603)	43	7
8	Offset Barber and Beauty Revenue	(115)	40	8
9	Disallowed Marketing Expense	(31,406)	43	9
10	Pet Expense	(945)	43	10
11	Offset Cable TV Revenue	(480)	43	11
12	Disallowed Equipment Rental Revenue	(1,233)	6	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**	(67,197)		49

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,523	$ 4,523	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	19	19	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	68	68	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	238	238	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,137	2,137	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%	63	63	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	247,300	Petersen Health Care Management, Inc.	100.00%	68,907	(178,393)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,164	14,164	12
13	V								13
14	Total			$ 247,300			$ 90,119	$ * (157,181)	14

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 106	$ 106	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	48,676	48,676	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	21,894	21,894	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	135	135	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	67	67	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,241	3,241	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	859	859	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	11,592	11,592	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	104	104	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	377	377	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	260	260	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,374	1,374	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			$			$ 88,685	$ * 88,685	39

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	6	Maintenance	$	Petersen Health Care-Roseville LLC	100.00%	3,551	$ 3,551	15
16	V	19	Professional Fees		Petersen Health Care-Roseville LLC	100.00%			16
17	V	21	Equipment	$	Petersen Health Care-Roseville LLC	100.00%	6,784	6,784	17
18	V	26	Property Insurance		Petersen Health Care-Roseville LLC	100.00%	30,305	30,305	18
19	V	26	Mortgage Insurance		Petersen Health Care-Roseville LLC	100.00%	15,346	15,346	19
20	V	30	Depreciation		Petersen Health Care-Roseville LLC	100.00%	146,523	146,523	20
21	V	31	Amortization		Petersen Health Care-Roseville LLC	100.00%	993	993	21
22	V	32	Interest	221	Petersen Health Care-Roseville LLC	100.00%	114,169	113,948	22
23	V	33	Real Estate Taxes		Petersen Health Care-Roseville LLC	100.00%	117,683	117,683	23
24	V	34	Rent-Facility & Grounds	593,837	Petersen Health Care-Roseville LLC	100.00%		(593,837)	24
25	V								25
26	V								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			$ 594,058			$ 435,354	$ * (158,704)	39

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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, L	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 Entery	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 Systen	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,451,714	75	$ 325,901	$ 376,129	20,146	$ 4,523	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	20,146	19	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	20,146	68	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	20,146	238	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	20,146	2,137	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,146	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	20,146	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	20,146	63	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	20,146	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,146	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	20,146	68,907	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	20,146	14,164	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	20,146	106	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	20,146	48,676	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	20,146	21,894	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	20,146	135	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	20,146	67	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	20,146	3,241	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	20,146	859	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	20,146	11,592	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	20,146	104	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	20,146	377	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	20,146	260	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	20,146	1,374	24
25	TOTALS					$ 12,790,903	$ 11,700,485		$ 178,804	25

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$44,073.00	4/1/10	$ 3,998,669	$ 2,971,384	3/31/39	0.0614	$ 114,169	1
2	Ford Credit		X	Vehicle	$752.57	3/25/14	38,605	10,011	3/24/19	0.0624	902	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,825.57		$ 4,037,274	$ 2,981,395			$ 115,071	9
	B. Non-Facility Related*											
10								Interest Income Offset			(855)	10
11								Home Office Allocation-PHCM			377	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (478)	14
15	TOTALS (line 9+line14)						$ 4,037,274	$ 2,981,395			$ 114,593	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 15,346 Line # 26

*** 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.)**

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	125,700	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.)	$	119,891	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,809)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	123,492	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** 260 **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.	$	117,943	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	116,451	8
	2013	112,420	9
	2014	111,975	10
	2015	122,043	11
	2016	119,891	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Roseville Rehabilitation & Health Care COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0050849

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-050-089-10	Land	$ 519.24	$ 519.24
2.	07-050-090-00	Nursing Facility	$ 119,313.72	$ 119,313.72
3.	07-050-107-00	Land	$ 57.90	$ 57.90
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 119,890.86	$ 119,890.86

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,817 B. General Construction Type: Exterior Brick Frame Block 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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 21,596 2. Number of Years Over Which it is Being Amortized: 21

3. Current Period Amortization: 1,097 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2010	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2010		$ 2,998,669	$	25	$ 119,947	$ 34,053	$ 779,655	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater			2013	5,776		7	822	822	2,877	9
10	Carpeting for Activity Room and Main Hallway			2013	10,088		15	672	672	2,352	10
11	Water Heater			2014	3,228		7	461	461	1,229	11
12	Shower Room Installation			2016	17,484		15	1,166	1,166	1,749	12
13	Boiler			2017	18,608		15	620	620	620	13
14	Removal of Trees			2017	2,650		7	189	189	189	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	Building Booked					119,947			(119,947)		31
32	Building Improvement Booked					3,808			(3,808)		32
33											33
34	2017-Home Office Allocation-Building Improvements				9,215			221	221		34
35	2017-Home Office Allocation-Land Improvements				848			55	55		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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,066,566	$ 123,755		$ 124,153	$ (85,496)	$ 788,671	70

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 641,377	$ 27,340	$ 65,407	$ 38,067	5-10 yrs.	$ 398,672	71
72	Current Year Purchases	7,850	1,120	561	(559)	7 yrs.	561	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,316	11,316			74
75	TOTALS	$ 649,227	$ 28,460	$ 77,284	$ 48,824		$ 399,233	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	Van	2012	$ 38,000	$ 3,167	$ 3,167	$		$ 38,000	76
77	Facility	Ford E250	2014	41,349	8,270	8,270			28,945	77
78										78
79										79
80	TOTALS			$ 79,349	$ 11,437	$ 11,437	$		$ 66,945	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)	$	4,195,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	163,652	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	212,874	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	49,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,254,849	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					88
89	N/A				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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 7,410 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.

Roseville Rehabilitation & Health Care
0050849
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	4,007
Copier		2,029
Home Office Allocation		1,374
		7,410

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,790	$ 101,851	$	6,790	$ 101,851	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		522	7,823		522	7,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,746	131,188	15	8,746	131,203	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				21,508		21,508	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			$	16,058	$ 240,862	$ 21,523	16,058	$ 262,385	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.

STATE OF ILLINOIS

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ (21,030)	$ (20,830)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 79,653)	891,442	891,442	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,947	22,738	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	45	45	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 889,404	$ 893,395	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		3,007,884	14
15	Leasehold Improvements, at Historical Cost	21,742	58,682	15
16	Equipment, at Historical Cost	106,703	728,576	16
17	Accumulated Depreciation (book methods)	(88,812)	(1,254,849)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,596	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(7,696)	20
21	Restricted Funds		888,311	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,633	$ 3,842,504	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 929,037	$ 4,735,899	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 753,552	$ 775,931	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,352	48,352	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,454	1,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,492	32
33	Accrued Interest Payable		9,286	33
34	Deferred Compensation	2,032	2,032	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	59,231	59,231	36
37	Accrued Management Fees	1,541,889	1,541,889	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,406,510	$ 2,561,667	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,011	10,011	39
40	Mortgage Payable		2,971,384	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	100,000	100,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 110,011	$ 3,081,395	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,516,521	$ 5,643,062	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,587,484)	$ (907,163)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 929,037	$ 4,735,899	48

***(See instructions.)**

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,473,631)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	3,718	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,469,913)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(72,071)	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	(45,500)	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)**	$ (117,571)	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)**	$ (1,587,484)	24 *

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,991,258	1
2	Discounts and Allowances for all Levels	(110,425)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,880,833	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	428,373	6
7	Oxygen	787	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 429,160	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	5,936	13
14	Non-Patient Meals	7,259	14
15	Telephone, Television and Radio	480	15
16	Rental of Facility Space		16
17	Sale of Drugs	34,510	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,318	20
21	Other Medical Services	11,210	21
22	Laundry	50	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,763	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	634	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 634	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	24,650	28
28a	Miscellaneous Revenue & Equipment Rental	4,306	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,956	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,410,346	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	604,646	31
32	Health Care	1,453,476	32
33	General Administration	528,335	33
	B. Capital Expense		
34	Ownership	617,904	34
	C. Ancillary Expense		
35	Special Cost Centers	109,092	35
36	Provider Participation Fee	168,964	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,482,417	40
41	**Income before Income Taxes (line 30 minus line 40)****	(72,071)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (72,071)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,511,740	44
45	Private Pay - Net Inpatient Revenue	1,088,965	45
46	Medicare - Net Inpatient Revenue	270,987	46
47	Other-(specify) Insurance Net Inpatient Revenue	9,141	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,880,833	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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,705	1,765	$ 59,136	$ 33.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,153	7,234	191,156	26.42	3
4	Licensed Practical Nurses	8,006	8,135	173,583	21.34	4
5	CNAs & Orderlies	33,564	35,523	438,603	12.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,788	1,877	23,433	12.48	9
10	Activity Assistants	2,127	2,177	19,521	8.97	10
11	Social Service Workers	1,974	2,025	30,059	14.84	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,072	13.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,188	13,409	122,799	9.16	15
16	Dishwashers					16
17	Maintenance Workers	1,671	1,771	44,605	25.19	17
18	Housekeepers	9,198	9,535	111,870	11.73	18
19	Laundry	1,886	2,030	39,088	19.26	19
20	Administrator	2,080	2,080	68,907	33.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,935	1,985	29,704	14.96	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	520	520	13,995	26.91	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	120	120	1,667	13.89	31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	6,491	6,664	116,658	17.51	33
34	TOTAL (lines 1 - 33)	95,486	98,930	$ 1,513,856 *	$ 15.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,220	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	347	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	$ 17,567		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	548	24,735	L10, C3	51
52	Certified Nurse Assistants/Aides	2,035	66,140	L10, C3	52
53	TOTAL (lines 50 - 52)	2,583	$ 90,875		53

Roseville Rehabilitation & Health Care
0050849
Period Beginning **1/1/2017**
Period End **12/31/2017**

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		2,021	2,037	48,632	23.87
Beauty/Barber Shop		514	514	7,396	14.39
Transportation		1,899	2,056	29,224	14.21
Marketing		2,057	2,057	31,406	15.27
	TOTAL	6,491	6,664	116,658	

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Gossage	Administrator	0	$ 29,104
Janet Holmberg	Administrator	0	39,803
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,907

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 247,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 247,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frontier	Computer Services	$ 1,079
Ginoli & Company	Accounting Services	6,205
ProTitle USA	Filing Fees	105
Mediacom	Computer Services	2,527
Honkamp Kruger	Accounting Services	583
Ability Network	Computer Services	3,079
Sorling Northrup	Legal Fees	20,873
Community National Bank	Legal Fees	40
Jane Crain & Katz Nowinski	Legal Settlement	28,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 62,491

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,700
Unemployment Compensation Insurance	12,130
FICA Taxes	107,904
Employee Health Insurance	729
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	313
Home Office Allocation	21,894
TOTAL (agree to Schedule V, line 22, col.8)	$ 177,670

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	119
Health Care Worker Background Check	
(Indicate # of checks performed 263)	2,100
Miscellaneous Licenses & Permits	411
Miscellaneous Dues & Subscriptions	952
Home Office Allocation	106
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,668

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	67
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 67

**See instructions.

Roseville Rehabilitation & Health Care
0050849
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		62,491
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	162
Arnstein & Lehr	Legal	1088
SB2	Legal	684
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	173
Smith Amundsen	Legal	67
Healthcare Resources International	Legal	120
Hunziker Law	Legal	1
Lexis Nexis	Legal	7
Baker Tilly Virchow Krause	Legal	607
CliftonLarsonAllen	Accounting	1944
Ginoli & Co.	Accounting	382
Baker Tilly Virchow Krause	Accounting	121
Miscellaneous	Computer Services	90
Change Healthcare	Computer Services	8
360 Networks	Computer Services	37
Matrix Care	Computer Services	3390
Stratus Networks	Computer Services	405
Kemper Technology	Computer Services	230
AT&T	Computer Services	6
Ability Network	Computer Services	250
CIAN	Computer Services	282
Comcast	Computer Services	16
CCH	Computer Services	14
Charter Communications	Computer Services	28
Allscripts	Computer Services	251
ATS	Computer Services	258
Citrix Systems	Computer Services	24
Optimizer	Other Prof Fees	45
Ankura	Other Prof Fees	730
David Budde	Other Prof Fees	34
Sargent Consulting	Other Prof Fees	2028
Alix Partners	Other Prof Fees	493
Demonica Kemper	Other Prof Fees	30
Brad Barkley	Other Prof Fees	119
MPAC Healthcare	Other Prof Fees	18
Higgs Appraisal	Other Prof Fees	8
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		76,657

Roseville Rehabilitation & Health Care
0050849
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC & PHCM		
MusilloUnkenholt, LLC	Legal	162
Arnstein & Lehr	Legal	1088
SB2	Legal	684
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	173
Smith Amundsen	Legal	67
Healthcare Resources International	Legal	120
Hunziker Law	Legal	1
Lexis Nexis	Legal	7
Baker Tilly Virchow Krause	Legal	607
Direct Facility Invoices		
ProTitle USA-Title and Lien Search	2/1/2017	105
Sorling Northrup-Taylor Case	2/6/2017	973
Sorling Northrup-Crain Case	5/5/2017	1,610
Sorling Northrup-Crain Case	6/7/2017	75
Community National Bank-Legal Fees	7/31/2017	40
Sorling Northrup-Crain Case	7/11/2017	17,667
Jane Crain-Settlement	9/20/2017	11,062
Katz Nowinski, PC	10/25/2017	16,938
Sorling Northrup-Crain Case	10/10/2017	205
Sorling Northrup-Taylor Case	10/10/2017	149
Sorling Northrup-Crain Case	11/8/2017	195
Disallowed Settlement	10/25/2017	(28,000)
Total Legal Fees (agree to Schedule V, line 19, column 8		23,940

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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? **Yes**
If YES, give association name and amount. **IHCA-$952**

(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. $ **19,148** 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. $ **168,964**
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. $ **7,259**

(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. $ **24,650**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees