FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0054379

Facility Name: Shawnee Rose Care Center

Address: 1000 West Sloan Street (Number) Harrisburg (City) 62946 (Zip Code)

County: Saline

Telephone Number: (618) 252-3905 **Fax #** (618) 253-4308

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2009

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 Shawnee Rose Care Center # 0054379 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	68	Skilled (SNF)	68	24,820	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	68	TOTALS	68	24,820	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	7,045	1,906	1,258	10,209	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,045	1,906	1,258	10,209	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.13%

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 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 1,172

Medicare Intermediary National Government Services

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 Shawnee Rose Care Center # 0054379 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	105,438	10,561		115,999		115,999	2,292	118,291			1
2	Food Purchase		71,445		71,445		71,445	(2,357)	69,088			2
3	Housekeeping	57,265	14,799		72,064		72,064	34	72,098			3
4	Laundry	7,770	6,458		14,228		14,228		14,228			4
5	Heat and Other Utilities			59,257	59,257		59,257	120	59,377			5
6	Maintenance	24,414	3,370	18,755	46,539		46,539	1,083	47,622			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	194,887	106,633	78,012	379,532		379,532	1,172	380,704			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	499,344	28,961	2,770	531,075		531,075	(10)	531,065			10
10a	Therapy			145,765	145,765		145,765		145,765			10a
11	Activities	21,920	312	218	22,450		22,450	(10,684)	11,766			11
12	Social Services	23,382			23,382		23,382		23,382			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	544,646	29,273	160,753	734,672		734,672	(10,694)	723,978			16
	C. General Administration											
17	Administrative			160,300	160,300		160,300	(99,197)	61,103			17
18	Directors Fees											18
19	Professional Services			9,872	9,872		9,872	7,177	17,049			19
20	Dues, Fees, Subscriptions & Promotions			3,909	3,909		3,909	54	3,963			20
21	Clerical & General Office Expenses		1,215	6,302	7,517		7,517	24,667	32,184			21
22	Employee Benefits & Payroll Taxes			93,332	93,332		93,332	11,095	104,427			22
23	Inservice Training & Education							68	68			23
24	Travel and Seminar							34	34			24
25	Other Admin. Staff Transportation			2,376	2,376		2,376	1,642	4,018			25
26	Insurance-Prop.Liab.Malpractice			21,797	21,797		21,797	435	22,232			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**		1,215	297,888	299,103		299,103	(54,025)	245,078			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	739,533	137,121	536,653	1,413,307		1,413,307	(63,547)	1,349,760			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 Shawnee Rose Care Center #0054379 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,098	1,098		1,098	76,086	77,184			30
31	Amortization of Pre-Op. & Org.							2,436	2,436			31
32	Interest							42,299	42,299			32
33	Real Estate Taxes			25,966	25,966		25,966	5,116	31,082			33
34	Rent-Facility & Grounds			122,796	122,796		122,796	(122,796)				34
35	Rent-Equipment & Vehicles			24,742	24,742		24,742	696	25,438			35
36	Other (specify):*											36
37	**TOTAL Ownership**			174,602	174,602		174,602	3,837	178,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,954		34,954		34,954		34,954			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,570	91,570		91,570		91,570			42
43	Other (specify):*		11	60,557	60,568		60,568	(60,568)				43
44	**TOTAL Special Cost Centers**		34,965	152,127	187,092		187,092	(60,568)	126,524			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	739,533	172,086	863,382	1,775,001		1,775,001	(120,278)	1,654,723			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 Shawnee Rose Care Center # 0054379 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	(2,367)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,294)	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	19,660	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	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	(13,737)	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	(38,000)	43		24
25	Fund Raising, Advertising and Promotional	(566)	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	(15,641)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,024)		$	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)	(66,254)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (66,254)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (120,278)		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

Shawnee Rose Care Center

ID# 0054379

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,498)	43	1
2	X-Rays-Part A	(1,460)	43	2
3	Disallowed Special Events	(977)	43	3
4	Pet Expense	(980)	43	4
5	Transportation Revenue Offset	(10,684)	11	5
6	Offset Misellaneous Nursing Supplies Revenue	(42)	10	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
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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**	(15,641)		49

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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%	$ 2,292	$ 2,292	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	10	10	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	34	34	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	120	120	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,083	1,083	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%	32	32	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	160,300	Petersen Health Care Management, Inc.	100.00%	61,103	(99,197)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,177	7,177	12
13	V								13
14	Total			$ 160,300			$ 71,851	$ * (88,449)	14

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

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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%	$ 54	$ 54	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	24,667	24,667	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	11,095	11,095	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	68	68	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	34	34	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,642	1,642	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	435	435	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	5,874	5,874	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	53	53	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	191	191	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	132	132	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	696	696	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			$			$ 44,941	$ * 44,941	39

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

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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	19	Professional Services	$	Petersen VII, LLC	100.00%		$	15
16	V	26	Insurance-Property		Petersen VII, LLC	100.00%			16
17	V	26	Insurance-MIP		Petersen VII, LLC	100.00%			17
18	V	30	Depreciation		Petersen VII, LLC	100.00%	50,552	50,552	18
19	V	31	Amortization		Petersen VII, LLC	100.00%	2,383	2,383	19
20	V	32	Interest		Petersen VII, LLC	100.00%	42,131	42,131	20
21	V	33	Real Estate Taxes		Petersen VII, LLC	100.00%	4,984	4,984	21
22	V	34	Rent-Income and Grounds	122,796	Petersen VII, LLC	100.00%		(122,796)	22
23	V								23
24	V								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			$ 122,796			$ 100,050	$ * (22,746)	39

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

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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 Entert	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 LL	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	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 Shawnee Rose Care Center # 0054379 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 Shawnee Rose Care Center # 0054379 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 Shawnee Rose Care Center # 0054379 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 Shawnee Rose Care Center # 0054379 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 Shawnee Rose Care Center # 0054379 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	10,209	$ 2,292	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	10,209	10	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	10,209	34	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	10,209	120	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	10,209	1,083	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	10,209	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	10,209	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	10,209	32	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	10,209	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	10,209	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	10,209	61,103	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	10,209	7,177	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	10,209	54	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	10,209	24,667	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	10,209	11,095	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	10,209	68	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	10,209	34	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	10,209	1,642	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	10,209	435	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	10,209	5,874	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	10,209	53	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	10,209	191	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	10,209	132	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	10,209	696	24
25	TOTALS					$ 12,790,903	$ 11,700,485		$ 116,792	25

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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	Harris Frank, LLC		X	Mortgage	Varies	5/20/16	$ 1,000,000	$ 889,126	5/20/41	Varies	$ 42,131	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,000,000	$ 889,126			$ 42,131	9
	B. Non-Facility Related*											
10								Interest Income Offset			(23)	10
11								Home Office Allocation-PHCM			191	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 168	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 889,126			$ 42,299	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.)**

Facility Name & ID Number Shawnee Rose Care Center # 0054379 **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.**	$	19,244	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.)	$	25,966	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,722	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	24,228	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** 132 **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.	$	31,082	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	23,265	8
	2013	25,774	9
	2014	25,469	10
	2015	25,608	11
	2016	25,966	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 Shawnee Rose Care Center COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0054379

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.	06-2-656-01	Long-Term Care Facility	$ 23,852.94	$ 23,852.94
2.	06-2-655-10	Long-Term Care Facility	$ 2,112.92	$ 2,112.92
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,965.86	$ 25,965.86

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 Shawnee Rose Care Center # 0054379 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,455 B. General Construction Type: Exterior Brick Frame _____ 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: 126,071 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 2,436 4. Dates Incurred: 2015-2016

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	108,900	2009	$ 140,000	1
2					2
3	TOTALS	108,900		$ 140,000	3

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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	68		2009	1976	$ 1,050,000	$	25	$ 42,000	$ 34,053	$ 357,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	A/C Unit			2009	4,500		5			4,500	9
10	Sprinkler System			2013	102,300		25	4,092	4,092	18,414	10
11	Door Alarm System			2015	4,273		7	610	610	1,220	11
12	Water Drain Line Repair			2016	4,000		7	286	286	572	12
13	Water Drain Line Repair			2017	3,580		7	256	256	256	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	Land Improvements Booked					64			(64)		30
31	Building Booked					42,000			(42,000)		31
32	Building Improvement Booked					5,800			(5,800)		32
33											33
34	2017-Home Office Allocation-Building Improvements				4,670			112	112		34
35	2017-Home Office Allocation-Land Improvements				430			28	28		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 Shawnee Rose Care Center # 0054379 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)		$ 1,173,753	$ 47,864		$ 47,384	$ (8,427)	$ 381,962	70

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

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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	$ 240,652	$ 3,786	$ 24,066	$ 20,280	5-10 yrs.	$ 194,298	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,734	5,734			74
75	TOTALS	$ 240,652	$ 3,786	$ 29,800	$ 26,014		$ 194,298	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	2010 Ford Van	2010	$ 29,543	$	$	$		$ 29,543	76
77										77
78										78
79										79
80	TOTALS			$ 29,543	$	$	$		$ 29,543	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)	$ 1,583,948	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,650	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,184	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,534	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 605,803	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 Shawnee Rose Care Center # 0054379 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: $ 25,438 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.

Shawnee Rose Care Center
0054379
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	$	20,027
Dishwasher		763
Copier		3,952
Home Office Allocation		696
		25,438

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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 Shawnee Rose Care Center # 0054379 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	$	3,759	$ 56,387	$	3,759	$ 56,387	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,148	32,224		2,148	32,224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,810	57,154		3,810	57,154	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				34,954		34,954	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			$	9,717	$ 145,765	$ 34,954	9,717	$ 180,719	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 Shawnee Rose Care Center # 0054379 **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	$ 260,291	$ 260,291	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,930)	586,330	586,330	3
4	Supply Inventory (priced at Cost)	4,183	4,183	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,942	14,942	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 865,746	$ 865,746	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		140,000	13
14	Buildings, at Historical Cost		1,054,670	14
15	Leasehold Improvements, at Historical Cost	7,580	119,083	15
16	Equipment, at Historical Cost	29,543	270,195	16
17	Accumulated Depreciation (book methods)	(30,641)	(605,803)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	260,526	257,620	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 267,008	$ 1,235,765	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,132,754	$ 2,101,511	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 348,798	$ 348,798	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,618	42,618	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,224	12,224	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,228	24,228	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	58,401	58,401	36
37	Accrued Management Fees	1,035,901	1,035,901	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,522,170	$ 1,522,170	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		889,126	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 889,126	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,522,170	$ 2,411,296	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (389,416)	$ (309,785)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,132,754	$ 2,101,511	48

***(See instructions.)**

Facility Name & ID Number Shawnee Rose Care Center # 0054379 **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**	$ (385,442)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Report Was Filed**	1,531	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (383,911)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,505)	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)**	$ (5,505)	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)**	$ (389,416)	24 *

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

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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	$ 1,506,622	1
2	Discounts and Allowances for all Levels	(131,905)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,374,717	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	294,880	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 294,880	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,367	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,856	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,654	20
21	Other Medical Services	5,273	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 89,150	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	10,684	28
28a	Miscellaneous Revenue	42	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,726	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,769,496	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	379,532	31
32	Health Care	734,672	32
33	General Administration	299,103	33
	B. Capital Expense		
34	Ownership	174,602	34
	C. Ancillary Expense		
35	Special Cost Centers	95,522	35
36	Provider Participation Fee	91,570	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,775,001	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,505)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,505)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 866,446	44
45	Private Pay - Net Inpatient Revenue	249,717	45
46	Medicare - Net Inpatient Revenue	244,218	46
47	Other-(specify) Insurance Net Inpatient Revenue	14,336	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,374,717	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 Shawnee Rose Care Center # 0054379 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	1,930	1,970	$ 47,398	$ 24.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,086	3,190	60,219	18.88	3
4	Licensed Practical Nurses	7,081	7,309	107,747	14.74	4
5	CNAs & Orderlies	21,046	21,949	244,405	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,625	1,633	21,920	13.42	9
10	Activity Assistants					10
11	Social Service Workers	1,730	1,730	23,382	13.52	11
12	Dietician					12
13	Food Service Supervisor	1,781	1,925	25,811	13.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,151	8,519	79,627	9.35	15
16	Dishwashers					16
17	Maintenance Workers	1,607	1,633	24,414	14.95	17
18	Housekeepers	6,335	6,495	57,265	8.82	18
19	Laundry	800	800	7,770	9.71	19
20	Administrator	2,080	2,080	61,103	29.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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) CPC	1,959	2,056	39,575	19.25	33
34	TOTAL (lines 1 - 33)	59,211	61,289	$ 800,636 *	$ 13.06	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	2,214	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	9	464	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)	9	$ 14,678		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Shawnee Rose Care Center # 0054379 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Allison Bienko	Administrator	0	$ 35,270
Mary Watson	Administrator	0	25,833
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,103

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 160,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 160,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 4,567
Clearwave Communications	Computer Services	839
Mediacom	Computer Services	1,635
Honkamp Krueger	Accounting Services	496
Black, Ballard, McDonald	Legal Fees	2,172
Saline County Circuit Clerk	Legal Fees	163
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 9,872

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,834
Unemployment Compensation Insurance	13,867
FICA Taxes	53,709
Employee Health Insurance	1,041
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	881
Home Office Allocation	11,095
TOTAL (agree to Schedule V, line 22, col.8)	$ 104,427

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	$ 1,870
Advertising: Employee Recruitment	58
Health Care Worker Background Check	
(Indicate # of checks performed 105)	571
Miscellaneous Licenses & Permits	458
Miscellaneous Dues & Subscriptions	952
Home Office Allocation	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,963

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	34
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34

**See instructions.

Shawnee Rose Care Center
0054379
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)		9,872
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	82
Arnstein & Lehr	Legal	551
SB2	Legal	346
Miscellaneous	Legal	6
Miller Hall and Triggs	Legal	88
Smith Amundsen	Legal	34
Healthcare Resources International	Legal	61
Hunziker Law	Legal	0
Lexis Nexis	Legal	4
Baker Tilly Virchow Krause	Legal	308
CliftonLarsonAllen	Accounting	985
Ginoli & Co.	Accounting	193
Baker Tilly Virchow Krause	Accounting	61
Miscellaneous	Computer Services	47
Change Healthcare	Computer Services	4
360 Networks	Computer Services	19
Matrix Care	Computer Services	1718
Stratus Networks	Computer Services	205
Kemper Technology	Computer Services	116
AT&T	Computer Services	3
Ability Network	Computer Services	126
CIAN	Computer Services	143
Comcast	Computer Services	8
CCH	Computer Services	7
Charter Communications	Computer Services	14
Allscripts	Computer Services	127
ATS	Computer Services	131
Citrix Systems	Computer Services	12
Optimizer	Other Prof Fees	23
Ankura	Other Prof Fees	370
David Budde	Other Prof Fees	17
Sargent Consulting	Other Prof Fees	1028
Alix Partners	Other Prof Fees	250
Demonica Kemper	Other Prof Fees	15
Brad Barkley	Other Prof Fees	60
MPAC Healthcare	Other Prof Fees	9
Higgs Appraisal	Other Prof Fees	4
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		17,049

Facility Name & ID Number Shawnee Rose Care Center # 0054379 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. $ **2,723** 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. $ **91,570**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,367**

(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. $ **10,684**
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? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees