

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0054379

Facility Name: Shawnee Rose Care Center

Address: 1000 West Sloan St Harrisburg 62946
Number City 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
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
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 1/1/2016 to 12/31/2016 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)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed)
(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

#	0054379	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/1/2009 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 60 and days of care provided

Medicare Intermediary National Government Services

MODIFIEDACCRUAL ☒

CASH*	
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CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2016 **Fiscal Year:** 12/31/2016

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

	1 Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,737	2,975	1,061	12,773	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,737	2,975	1,061	12,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	51.46%
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Facility Name & ID Number Shawnee Rose Care Center # 0054379 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	108,743	11,479	1,197	121,419		121,419	2,624	124,043			1
2	Food Purchase		85,280		85,280		85,280	(2,490)	82,790			2
3	Housekeeping	60,912	15,683		76,595		76,595	46	76,641			3
4	Laundry	12,377	5,883	261	18,521		18,521		18,521			4
5	Heat and Other Utilities			66,617	66,617		66,617	153	66,770			5
6	Maintenance	32,733	7,674	17,048	57,455		57,455	1,432	58,887			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	214,765	125,999	85,123	425,887		425,887	1,765	427,652			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	514,433	31,308	2,084	547,825		547,825	(1,386)	546,439			10
10a	Therapy			126,837	126,837		126,837		126,837			10a
11	Activities	20,686	85	159	20,930		20,930	(6,744)	14,186			11
12	Social Services	22,944			22,944		22,944		22,944			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	558,063	31,393	141,080	730,536		730,536	(8,130)	722,406			16
	C. General Administration											
17	Administrative			171,300	171,300		171,300	(114,676)	56,624			17
18	Directors Fees											18
19	Professional Services			6,076	6,076		6,076	9,720	15,796			19
20	Dues, Fees, Subscriptions & Promotions			9,633	9,633		9,633	4	9,637			20
21	Clerical & General Office Expenses		2,485	12,501	14,986		14,986	30,587	45,573			21
22	Employee Benefits & Payroll Taxes			129,444	129,444		129,444	17,103	146,547			22
23	Inservice Training & Education							59	59			23
24	Travel and Seminar							28	28			24
25	Other Admin. Staff Transportation			2,143	2,143		2,143	2,406	4,549			25
26	Insurance-Prop.Liab.Malpractice			20,885	20,885		20,885	339	21,224			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration		2,485	351,982	354,467		354,467	(54,430)	300,037			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	772,828	159,877	578,185	1,510,890		1,510,890	(60,795)	1,450,095			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			143	143		143	78,533	78,676			30
31	Amortization of Pre-Op. & Org.							794	794			31
32	Interest			28,585	28,585		28,585	15,433	44,018			32
33	Real Estate Taxes			23,656	23,656		23,656	2,399	26,055			33
34	Rent-Facility & Grounds			78,781	78,781		78,781	(78,781)				34
35	Rent-Equipment & Vehicles			20,802	20,802		20,802	550	21,352			35
36	Other (specify):*											36
37	TOTAL Ownership			151,967	151,967		151,967	18,928	170,895			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,043		43,043		43,043		43,043			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,873	108,873		108,873		108,873			42
43	Other (specify):*		383	39,815	40,198		40,198	(40,198)				43
44	TOTAL Special Cost Centers		43,426	148,688	192,114		192,114	(40,198)	151,916			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	772,828	203,303	878,840	1,854,971		1,854,971	(82,065)	1,772,906			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,538)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,006)	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	14,429	30		9
10	Interest and Other Investment Income	(169)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	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	(12,509)	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	(18,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,660)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(13,339)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,959)		\$	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)	(45,106)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,106)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (82,065)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,687)	43	1
2	X-Rays-Part A	(1,070)	43	2
3	Disallowed Special Events	(836)	43	3
4	Pet Expense	(1,263)	43	4
5	Offset Miscellaneous Office Supplies Revenue		21	5
6	Transportation Revenue Offset	(6,744)	11	6
7	Offset Misellaneous Nursing Supplies Revenue	(1,464)	10	7
8	Disallowed Chamber of Commerce Dues	(275)	20	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
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25				25
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28				28
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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	(13,339)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Rose Care Center# 0054379

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,624	0	0	0	0	0	0	0	0	0	2,624	1
2	Food Purchase	(2,538)	48	0	0	0	0	0	0	0	0	0	(2,490)	2
3	Housekeeping	0	46	0	0	0	0	0	0	0	0	0	46	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	153	0	0	0	0	0	0	0	0	0	153	5
6	Maintenance	0	1,432	0	0	0	0	0	0	0	0	0	1,432	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,538)	4,303	0	0	0	0	0	0	0	0	0	1,765	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,464)	78	0	0	0	0	0	0	0	0	0	(1,386)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,744)	0	0	0	0	0	0	0	0	0	0	(6,744)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(8,208)	78	0	0	0	0	0	0	0	0	0	(8,130)	16
	C. General Administration													
17	Administrative	0	(114,676)	0	0	0	0	0	0	0	0	0	(114,676)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,682	0	3,038	0	0	0	0	0	0	0	9,720	19
20	Fees, Subscriptions & Promotions	(275)	0	279	0	0	0	0	0	0	0	0	4	20
21	Clerical & General Office Expenses	0	0	30,587	0	0	0	0	0	0	0	0	30,587	21
22	Employee Benefits & Payroll Taxes	0	0	17,103	0	0	0	0	0	0	0	0	17,103	22
23	Inservice Training & Education	0	0	59	0	0	0	0	0	0	0	0	59	23
24	Travel and Seminar	0	0	28	0	0	0	0	0	0	0	0	28	24
25	Other Admin. Staff Transportation	0	0	2,406	0	0	0	0	0	0	0	0	2,406	25
26	Insurance-Prop.Liab.Malpractice	0	0	339	0	0	0	0	0	0	0	0	339	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(275)	(107,994)	50,801	3,038	0	0	0	0	0	0	0	(54,430)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,021)	(103,613)	50,801	3,038	0	0	0	0	0	0	0	(60,795)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Rose Care Center # 0054379 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	14,429	0	6,768	1,159	56,177	0	0	0	0	0	0	78,533	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	794	0	0	0	0	0	0	794	31
32	Interest	(169)	0	199	0	15,403	0	0	0	0	0	0	15,433	32
33	Real Estate Taxes	0	0	156	0	2,243	0	0	0	0	0	0	2,399	33
34	Rent-Facility & Grounds	0	0	0	0	(78,781)	0	0	0	0	0	0	(78,781)	34
35	Rent-Equipment & Vehicles	0	0	550	0	0	0	0	0	0	0	0	550	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	14,260	0	7,673	1,159	(4,164)	0	0	0	0	0	0	18,928	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(40,198)	0	0	0	0	0	0	0	0	0	0	(40,198)	43
44	TOTAL Special Cost Centers	(40,198)	0	0	0	0	0	0	0	0	0	0	(40,198)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,959)	(103,613)	58,474	4,197	(4,164)	0	0	0	0	0	0	(82,065)	45

VII. RELATED PARTIES

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

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

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 2,624</u>	<u>\$ 2,624</u>	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>48</u>	<u>48</u>	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>46</u>	<u>46</u>	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>153</u>	<u>153</u>	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>1,432</u>	<u>1,432</u>	5
6	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		6
7	V	9	<u>Medical Director</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>78</u>	<u>78</u>	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		10
11	V	17	<u>Administrative</u>	<u>171,300</u>	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>56,624</u>	<u>(114,676)</u>	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>6,682</u>	<u>6,682</u>	12
13	V								13
14	Total			\$ 171,300			\$ 67,687	\$ * (103,613)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 279	\$	279
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	30,587		30,587
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,103		17,103
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	59		59
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	28		28
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,406		2,406
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	339		339
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	6,768		6,768
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	199		199
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	156		156
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	550		550
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 58,474	\$ *	58,474

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Midwest Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Midwest Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Midwest Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Midwest Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Midwest Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Midwest Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Midwest Health Operations, LLC	100.00%	3,038	3,038	25
26	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Midwest Health Operations, LLC	100.00%	1,159	1,159	33
34	V	31	Amortization		Midwest Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Midwest Health Operations, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38
39	Total			\$			\$ 4,197	\$ * 4,197	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	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%	56,177	56,177	18
19	V	31	Amortization		Petersen VII, LLC	100.00%	794	794	19
20	V	32	Interest		Petersen VII, LLC	100.00%	15,403	15,403	20
21	V	33	Real Estate Taxes		Petersen VII, LLC	100.00%	2,243	2,243	21
22	V	34	Rent-Income and Grounds	78,781	Petersen VII, LLC	100.00%	0	(78,781)	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			\$ 78,781			\$ 74,617	\$ * (4,164)	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:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Shawnee Rose Care Center

0054379

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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:

1/1/2016

Ending:

12/31/2016

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:

1/1/2016

Ending:

12/31/2016

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: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Shawnee Rose Care Center# 0054379

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,521,544	75	\$ 312,540	\$ 357,910	12,773	\$ 2,624	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	12,773	48	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	12,773	46	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	12,773	153	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	12,773	1,432	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	12,773	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	12,773	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	12,773	78	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	12,773	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	12,773	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	12,773	56,624	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	12,773	6,682	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	12,773	279	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	12,773	30,587	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,521,544	75	2,037,314	0	12,773	17,103	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	12,773	59	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	12,773	28	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	12,773	2,406	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	12,773	339	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	12,773	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	12,773	6,768	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	12,773	199	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	12,773	156	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	12,773	550	24
25	TOTALS					\$ 13,089,501	\$ 11,510,481		\$ 126,161	25

Facility Name & ID Number Shawnee Rose Care Center# 0054379

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Midwest Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 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	101,374	10	\$	\$	7,732	\$	1
2	2	Food	Resident Days	101,374	10			7,732		2
3	3	Housekeeping	Resident Days	101,374	10			7,732		3
4	4	Laundry	Resident Days	101,374	10			7,732		4
5	5	Utilities	Resident Days	101,374	10			7,732		5
6	6	Maintenance	Resident Days	101,374	10			7,732		6
7	7	Mgmt. Allocation of Benefits	Resident Days	101,374	10			7,732		7
8	10	Nursing and Medical Records	Resident Days	101,374	10			7,732		8
9	15	Mgmt. Allocation of Benefits	Resident Days	101,374	10			7,732		9
10	17	Administrative	Resident Days	101,374	10			7,732		10
11	19	Professional Services	Resident Days	101,374	10	39,835		7,732	3,038	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	101,374	10			7,732		12
13	21	Clerical and General Office	Resident Days	101,374	10			7,732		13
14	22	Employee Benefits & Payroll	Resident Days	101,374	10			7,732		14
15	23	Inservice Training & Education	Resident Days	101,374	10			7,732		15
16	24	Travel and Seminar	Resident Days	101,374	10			7,732		16
17	25	Other Admin. Staff Transport.	Resident Days	101,374	10			7,732		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	101,374	10			7,732		18
19	30	Depreciation	Resident Days	101,374	10	15,191		7,732	1,159	19
20	31	Amortization	Resident Days	101,374	10			7,732		20
21	32	Interest	Resident Days	101,374	10			7,732		21
22	33	Real Estate Taxes	Resident Days	101,374	10			7,732		22
23	34	Rent-Facility and Grounds	Resident Days	101,374	10			7,732		23
24	35	Rent-Equipment & Vehicles	Resident Days	101,374	10			7,732		24
25	TOTALS					\$ 55,026	\$		\$ 4,197	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Harris Frank, LLC		X	Mortgage	Varies	5/20/16	\$ 1,000,000	\$ 963,490	5/20/41	Varies	\$ 43,988	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,000,000	\$ 963,490			\$ 43,988	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(169)	10	
11								Home Office Allocation-PHCM			199	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 30	14	
15	TOTALS (line 9+line14)						\$ 1,000,000	\$ 963,490			\$ 44,018	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.)

B. Real Estate Taxes

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.

2015 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 2015 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 2015.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>06-2-656-01</u>	<u>Long-Term Care Facility</u>	\$ <u>23,524.30</u>	\$ <u>23,524.30</u>
2.	<u>06-2-655-10</u>	<u>Long-Term Care Facility</u>	\$ <u>2,083.80</u>	\$ <u>2,083.80</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>25,608.10</u></u>	\$ <u><u>25,608.10</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

21,455

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

126,071

2. Number of Years Over Which it is Being Amortized:

5

3. Current Period Amortization:

794

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	108,900	2009	\$ 140,000	1
2					2
3	TOTALS	108,900		\$ 140,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	68		2009	1976	\$ 1,050,000	\$	25	\$ 42,000	\$ 42,000	\$ 315,000
5										
6										
7										
8										
	Improvement Type**									
9	A/C Unit		2009		4,500		5			4,500
10	Sprinkler System		2013		102,300		25	4,092	4,092	14,322
11	Door Alarm System		2015		4,273		7	305	305	610
12	Water Drain Line Repair		2016		4,000		7	286	286	286
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					63			(63)	
31	Building Booked					42,000			(42,000)	
32	Building Improvement Booked					5,167			(5,167)	
33										
34	2016-Home Office Allocation-Building Improvements				5,639			135	135	
35	2016-Home Office Allocation-Land Improvements				519			34	34	
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:

1/1/2016

Ending:

12/31/2016

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)		\$ 1,171,231	\$ 47,230		\$ 46,852	\$ (378)	\$ 334,718	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$240,652	\$9,090	\$24,066	\$14,976	5-10 yrs.	\$170,232	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,758	7,758			74
75	TOTALS	\$240,652	\$9,090	\$31,824	\$22,734		\$170,232	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	\$	\$	\$(4,924)		\$29,543	76
77										77
78										78
79										79
80	TOTALS			\$29,543	\$	\$	\$(4,924)		\$29,543	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,581,426	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$56,320	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$78,676	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$17,432	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$534,493	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.

☐ YES
☐ NO

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

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: \$ 21,352
- 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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	16,028
Dishwasher		701
Maintenance Equipment		30
Copier		4,043
Home Office Allocation		550
		<u>21,352</u>
		<u><u>21,352</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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.

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	\$	2,766	\$ 41,485	\$	2,766	\$ 41,485	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,909	28,641		1,909	28,641	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,781	56,711		3,781	56,711	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				43,043		43,043	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,456	\$ 126,837	\$ 43,043	8,456	\$ 169,880	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 574,906	\$ 574,906	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,004)	666,814	666,814	3
4	Supply Inventory (priced at Cost)	4,183	4,183	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,747	19,747	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	500	500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,266,150	\$ 1,266,150	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		1,055,639	14
15	Leasehold Improvements, at Historical Cost	4,000	115,592	15
16	Equipment, at Historical Cost	29,543	270,195	16
17	Accumulated Depreciation (book methods)	(29,686)	(534,493)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,857	\$ 1,046,933	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,270,007	\$ 2,313,083	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 396,702	\$ 396,702	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,793	46,793	30
31	Accrued Taxes Payable (excluding real estate taxes)	66,944	66,944	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,244	19,244	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	177,030	177,030	36
37	Accrued Management Fees	846,117	846,117	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,552,830	\$ 1,552,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		963,490	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	102,619	105,525	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 102,619	\$ 1,069,015	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,655,449	\$ 2,621,845	46
47	TOTAL EQUITY(page 18, line 24)	\$ (385,442)	\$ (308,762)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,270,007	\$ 2,313,083	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (390,831)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(5,642)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (396,473)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,031	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)	\$ 11,031	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)	\$ (385,442)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shawnee Rose Care Center

0054379

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,714,255	1
2	Discounts and Allowances for all Levels	(185,568)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,528,687	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	245,912	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 245,912	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	2,538	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	66,200	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,132	20
21	Other Medical Services	11,156	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,026	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	169	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 169	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	6,744	28
28a	<u>Miscellaneous Revenue</u>	1,464	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,208	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,866,002	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	425,887	31
32	Health Care	730,536	32
33	General Administration	354,467	33
	B. Capital Expense		
34	Ownership	151,967	34
	C. Ancillary Expense		
35	Special Cost Centers	83,241	35
36	Provider Participation Fee	108,873	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,854,971	40
41	Income before Income Taxes (line 30 minus line 40)**	11,031	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 11,031	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 910,954	44
45	Private Pay - Net Inpatient Revenue	430,279	45
46	Medicare - Net Inpatient Revenue	123,480	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	63,974	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,528,687	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,631	2,651	\$ 58,464	\$ 22.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,644	3,795	65,748	17.32	3
4	Licensed Practical Nurses	7,244	7,388	102,803	13.91	4
5	CNAs & Orderlies	18,893	19,903	248,876	12.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,032	20,686	10.18	9
10	Activity Assistants					10
11	Social Service Workers	1,803	1,856	22,944	12.36	11
12	Dietician					12
13	Food Service Supervisor	1,864	1,992	26,477	13.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,812	9,062	82,266	9.08	15
16	Dishwashers					16
17	Maintenance Workers	2,046	2,086	32,733	15.69	17
18	Housekeepers	6,864	7,145	60,912	8.53	18
19	Laundry	1,470	1,470	12,377	8.42	19
20	Administrator	2,080	2,080	56,624	27.22	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	2,027	2,051	38,542	18.79	33
34	TOTAL (lines 1 - 33)	61,410	63,511	\$ 829,452 *	\$ 13.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	20	\$ 1,197	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,173	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	404	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)	27	\$ 14,774		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID Number

Shawnee Rose Care Center

0054379

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Allison Bienko	Administrator	0	\$ 32,500	Workers' Compensation Insurance	\$ 51,950	IDPH License Fee	\$ 3,980	
Robert Emling	Administrator	0	24,124	Unemployment Compensation Insurance	20,093	Advertising: Employee Recruitment		
				FICA Taxes	54,396	Health Care Worker Background Check		
				Employee Health Insurance	1,678	(Indicate # of checks performed 36)	932	
				Employee Meals		Patient Background Checks 13	346	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	2,350	
				Employee Relations	1,327	Miscellaneous Dues & Subscriptions	2,025	
				Home Office Allocation	17,103	Home Office Allocation	279	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 56,624					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 171,300			Less: Public Relations Expense	()	
						Non-allowable advertising	(275)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 171,300	TOTAL (agree to Schedule V, line 22, col.8)	\$ 146,547	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,637	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		\$ 3,043					
Clearwave Communications	Computer Services		839					
Mediacom	Computer Services		1,496	N/A				
Honkamp Krueger	Accounting Services		667				In-State Travel	
Fifth Third Bank Legal Entry	Legal Fees		31					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 6,076				Home Office Allocation	28
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 28

* Attach copy of IMRF notifications

**See instructions.

Shawnee Rose Care Center
0054379
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,076
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	30
Miscellaneous	Legal	11
Miller Hall and Triggs	Legal	52
Healthcare Resources International	Legal	257
Hunziker Law	Legal	62
Lexis Nexis	Legal	5
Illinois Secretary of State	Legal	19
Hughes, Socol, Piers	Legal	763
SB2	Legal	915
CliftonLarson Allen	Accountants	268
Ginoli & Co.	Accountants	2,216
Miscellaneous	Computer Services	34
Change Healthcare	Computer Services	5
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	2,352
Stratus Networks	Computer Services	239
Kemper Technology	Computer Services	158
AT&T	Computer Services	3
Ability Network	Computer Services	1,003
CIAN	Computer Services	120
Comcast	Computer Services	19
CCH	Computer Services	8
Charter Communications	Computer Services	23
Allscripts	Computer Services	350
ATS	Computer Services	158
Allpayer Exchange	Computer Services	8
Optimizer	Other Prof Fees	24
Ankura	Other Prof Fees	183
David Budde	Other Prof Fees	21
Bruner, Cooper, Zuck	Other Prof Fees	53
Marotta, Gund, Budd, Dzerda	Other Prof Fees	329
Professional Software and Services	Other Prof Fees	13
Hughes Valuation Services	Other Prof Fees	16
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)

15,797

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?
If YES, give association name and amount.

Yes
IHCA \$1000

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 2,899 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 108,873

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 2,538

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 6,744

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

No

RECONCILIATION REPORT			Shawnee Rose Care Cen		12:08 PM	7/7/2017							
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-82,065	equal to	-82,065	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	44,018	equal to	44,018	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	26,055	equal to	26,055	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	794	equal to	794	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	78,676	equal to	78,676	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	21,352	equal to	21,352	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	126,837	equal to	126,837	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	43,043	equal to	43,043	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	425,887	equal to	425,887	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	730,536	equal to	730,536	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	354,467	equal to	354,467	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	151,967	equal to	151,967	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	83,241	equal to	83,241	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	108,873	equal to	108,873	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	514,433	equal to	514,433	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	20,686	equal to	20,686	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,944	equal to	22,944	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	108,743	equal to	108,743	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	32,733	equal to	32,733	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	60,912	equal to	60,912	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	12,377	equal to	12,377	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	56,624	equal to	56,624	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		#VALUE!	#VALUE!	Pg20 K33..,K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	829,452	equal to	772,828	56,624	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,197	< or = to	1,197	0	FAILED	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,577	< or = to	2,084	-507	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	159	-159	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	56,624	equal to	56,624	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	171,300	equal to	171,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	6,076	equal to	6,076	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	146,547	equal to	146,547	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	9,637	equal to	9,637	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	28	equal to	28	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	108,873	equal to	108,873	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	883	equal to	1,061	-178	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-45,106	equal to	-45,106	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	963,490	equal to	963,490	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	19,244	equal to	19,244	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	140,000	equal to	140,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,171,231	equal to	1,171,231	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	270,195	equal to	270,195	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	534,493	equal to	534,493	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-385,442	equal to	-385,442	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	11,031	equal to	11,031	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,270,007	equal to	1,270,007	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	108,743	11,479	1,197	121,419	0	121,419	2,624	124,043
2. Food Purchase	0	85,280	0	85,280	0	85,280	-2,490	82,790
3. Housekeeping	60,912	15,683	0	76,595	0	76,595	46	76,641
4. Laundry	12,377	5,883	261	18,521	0	18,521	0	18,521
5. Heat and Other Utilities	0	0	66,617	66,617	0	66,617	153	66,770
6. Maintenance	32,733	7,674	17,048	57,455	0	57,455	1,432	58,887
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	214,765	125,999	85,123	425,887	0	425,887	1,765	427,652
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	514,433	31,308	2,084	547,825	0	547,825	-1,386	546,439
10a. Therapy	0	0	126,837	126,837	0	126,837	0	126,837
11. Activities	20,686	85	159	20,930	0	20,930	-6,744	14,186
12. Social Services	22,944	0	0	22,944	0	22,944	0	22,944
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	558,063	31,393	141,080	730,536	0	730,536	-8,130	722,406
17. Administrative	0	0	171,300	171,300	0	171,300	-114,676	56,624
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	6,076	6,076	0	6,076	9,720	15,796
20. Fees, Subscriptions & Promotion	0	0	9,633	9,633	0	9,633	4	9,637
21. Clerical & General Office	0	2,485	12,501	14,986	0	14,986	30,587	45,573
22. Employee Benefits & Payroll	0	0	129,444	129,444	0	129,444	17,103	146,547
23. Inservice Training & Education	0	0	0	0	0	0	59	59
24. Travel and Seminar	0	0	0	0	0	0	28	28
25. Other Admin. Staff Trans	0	0	2,143	2,143	0	2,143	2,406	4,549
26. Insurance-Prop.Liab.Malpractice	0	0	20,885	20,885	0	20,885	339	21,224
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	2,485	351,982	354,467	0	354,467	-54,430	300,037
29. Total General Administrative	772,828	159,877	578,185	1,510,890	0	1,510,890	-60,795	#####
30. Depreciation	0	0	143	143	0	143	78,533	78,676
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	794	794
32. Interest	0	0	28,585	28,585	0	28,585	15,433	44,018
33. Real Estate	0	0	23,656	23,656	0	23,656	2,399	26,055
34. Rent - Facility & Grounds	0	0	78,781	78,781	0	78,781	-78,781	0
35. Rent - Equipment & Vehicles	0	0	20,802	20,802	0	20,802	550	21,352
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	151,967	151,967	0	151,967	18,928	170,895
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	43,043	0	43,043	0	43,043	0	43,043
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	108,873	108,873	0	108,873	0	108,873
43. Other (specify):*	0	383	39,815	40,198	0	40,198	-40,198	0
44. Total Special Cost Ce	0	43,426	148,688	192,114	0	192,114	-40,198	151,916
45. Grand Total	772,828	203,303	878,840	1,854,971	0	1,854,971	-82,065	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	574,906	574,906
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	666,814	666,814
4. Supply Inventory	4,183	4,183
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,747	19,747
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	500	500
10. Total current assets	1,266,150	1,266,150
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	140,000
14. Buildings, at Historical Cost	0	1,055,639
15. Leasehold Improvements, Historical Cost	4,000	115,592
16. Equipment, at Historical Cost	29,543	270,195
17. Accumulated Depreciation (book methods)	-29,686	-534,493
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	3,857	1,046,933
25. Total Assets	1,270,007	2,313,083
CURRENT LIABILITIES		
26. Accounts Payable	396,702	396,702
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	46,793	46,793
31. Accrued Taxes Payable	66,944	66,944
32. Accrued Real Estate Taxes	19,244	19,244
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	177,030	177,030
37. Other Current Liabilities (specify):	846,117	846,117
38. Total Current Liabilities	1,552,830	1,552,830
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	963,490
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	102,619	105,525
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	102,619	1,069,015
46.Total Liabilities	1,655,449	2,621,845
47.Total Equity	-385,442	-308,762
48.Total Liabilities and Equity	1,270,007	2,313,083

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,714,255
2. Discounts and Allowances for all Levels	-185,568
Subtotal - Inpatient Care	1,528,687
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	245,912
7. Oxygen	0
Subtotal - Ancillary Revenue	245,912
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,538
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	66,200
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	3,132
21. Other Medical Services	11,156
22. Laundry	0
Subtotal - Other Operating Revenue	83,026
24. Contributions	0
25. Interest and Other Investments Income	169
Subtotal - Non-Operating Revenue	169
27. Other Revenue (specify):	6,744
28. Other Revenue (specify):	1,464
Subtotal - Other Revenue	8,208
30. Total Revenue	1,866,002
31. General Services	464,442
32. Health Care	692,729
33. General Administration	296,105
34. Ownership	182,852
35. Special Cost Centers	57,556
35. Provider Participation Fee	121,397
37. Other	0
40. Total Expenses	1,815,081
41. Income Before Income Taxes	50,921
42. Income Taxes	0
43. Net Income or Loss for the Year	50,921