

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0050351</u></p> <p>Facility Name: <u>Shawnee Rose Care Center</u></p> <p>Address: <u>1000 West Sloan Street</u> <u>Harrisburg</u> <u>62946</u> <small>Number City Zip Code</small></p> <p>County: <u>Saline</u></p> <p>Telephone Number: <u>(618) 252-3905</u> Fax # <u>(618) 253-4308</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/09</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 689-5869</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: 1px solid black; vertical-align: top; padding: 5px;">Officer or Administrator of Provider</td> <td style="border: none;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="border: 1px solid black; vertical-align: top; padding: 5px;">Paid Preparer</td> <td style="border: none;"> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Shawnee Rose Care Center

0050351 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	6,474	1,826	1,534	9,834	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,474	1,826	1,534	9,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.62%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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 1,085

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

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	98,841	7,121		105,962		105,962	1,984	107,946		1
2	Food Purchase		61,232		61,232		61,232	(1,911)	59,321		2
3	Housekeeping	48,753	8,813		57,566		57,566	13	57,579		3
4	Laundry	27,417	4,424		31,841		31,841		31,841		4
5	Heat and Other Utilities			45,194	45,194		45,194	130	45,324		5
6	Maintenance	29,397	4,284	13,676	47,357		47,357	809	48,166		6
7	Other (specify):* Home Off. Ben. All.							452	452		7
8	TOTAL General Services	204,408	85,874	58,870	349,152		349,152	1,477	350,629		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	398,973	17,781	730	417,484		417,484	20	417,504		10
10a	Therapy			156,350	156,350		156,350		156,350		10a
11	Activities	18,684	1,302	441	20,427		20,427		20,427		11
12	Social Services	7,571			7,571		7,571		7,571		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	425,228	19,083	169,521	613,832		613,832	20	613,852		16
	C. General Administration										
17	Administrative			70,800	70,800		70,800	(10,300)	60,500		17
18	Directors Fees										18
19	Professional Services			5,204	5,204		5,204	3,045	8,249		19
20	Dues, Fees, Subscriptions & Promotions			5,876	5,876		5,876	(65)	5,811		20
21	Clerical & General Office Expenses		2,480	6,576	9,056		9,056	19,676	28,732		21
22	Employee Benefits & Payroll Taxes			257,773	257,773		257,773		257,773		22
23	Inservice Training & Education							66	66		23
24	Travel and Seminar							19	19		24
25	Other Admin. Staff Transportation			2,989	2,989		2,989	1,700	4,689		25
26	Insurance-Prop.Liab.Malpractice			22,538	22,538		22,538	460	22,998		26
27	Other (specify):* Home Off. Ben. All.							7,517	7,517		27
28	TOTAL General Administration		2,480	371,756	374,236		374,236	22,118	396,354		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	629,636	107,437	600,147	1,337,220		1,337,220	23,615	1,360,835		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

#0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			79,387	79,387		79,387	(6,378)	73,009		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			80,258	80,258		80,258	2,542	82,800		32
33	Real Estate Taxes			26,284	26,284		26,284	163	26,447		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			16,634	16,634		16,634	290	16,924		35
36	Other (specify):*										36
37	TOTAL Ownership			202,563	202,563		202,563	(3,383)	199,180		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		39,331		39,331		39,331		39,331		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			37,230	37,230		37,230		37,230		42
43	Other (specify):* <i>Non-allowable Costs</i>		931	19,151	20,082		20,082	(20,082)			43
44	TOTAL Special Cost Centers		40,262	56,381	96,643		96,643	(20,082)	76,561		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	629,636	147,699	859,091	1,636,426		1,636,426	150	1,636,576		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

0050351

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,920)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,492)	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	(9,035)	30		9
10	Interest and Other Investment Income	(656)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	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	(1,419)	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	(2,942)	43		24
25	Fund Raising, Advertising and Promotional	(3,821)	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	(9,805)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,214)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,364	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,364		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 150		37

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

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

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

Shawnee Rose Care Center

ID# 0050351

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,397)	43	1
2	X-Rays-Part A	(4,262)	43	2
3	Disallowed Special Events	(20)	43	3
4	Pet Expense	(605)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(296)	21	5
6	Disallow Chamber of Commerce Dues	(225)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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19				19
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34				34
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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		(9,805)	49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,984	\$ 1,984	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	9	9	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	13	13	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	130	130	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	809	809	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	452	452	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	20	20	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	70,800	Petersen Health Care, Inc.	100.00%	60,500	(10,300)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,270	2,270	12
13	V							13
14	Total		\$ 70,800			\$ 66,187	\$ * (4,613)	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, Inc.	100.00%	\$ 160	\$ 160	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,494	18,494	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	66	66	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	19	19	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,700	1,700	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	460	460	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,517	7,517	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,657	2,657	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,198	3,198	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	163	163	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	290	290	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		\$				\$ 34,724	\$ * 34,724	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Midwest Health Properties, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Midwest Health Properties, LLC	100.00%	0		16	
17	V	3 Housekeeping		Midwest Health Properties, LLC	100.00%	0		17	
18	V	4 Laundry		Midwest Health Properties, LLC	100.00%	0		18	
19	V	5 Utilities		Midwest Health Properties, LLC	100.00%	0		19	
20	V	6 Maintenance		Midwest Health Properties, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Midwest Health Properties, LLC	100.00%	0		22	
23	V	10A Therapy		Midwest Health Properties, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		24	
25	V	17 Administrative		Midwest Health Properties, LLC	100.00%	0		25	
26	V	19 Professional Services		Midwest Health Properties, LLC	100.00%	775	775	26	
27	V	20 Dues, Fees, Subs & Promotions		Midwest Health Properties, LLC	100.00%	0		27	
28	V	21 Clerical and General Office		Midwest Health Properties, LLC	100.00%	1,478	1,478	28	
29	V	22 Employee Benefits & Payroll		Midwest Health Properties, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Midwest Health Properties, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Midwest Health Properties, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Properties, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Midwest Health Properties, LLC	100.00%	0		33	
34	V	30 Depreciation		Midwest Health Properties, LLC	100.00%	0		34	
35	V	32 Interest		Midwest Health Properties, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Midwest Health Properties, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Midwest Health Properties, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Properties, LLC	100.00%	0		38	
39	Total		\$			\$ 2,253	\$ *	2,253	39

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

Facility Name & ID Number

Shawnee Rose Care Center

0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Shawnee Rose Care Center

0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Shawnee Rose Care Center

0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Shawnee Rose Care Center

0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								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

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# 0050351 Report Period Beginning: 1/1/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

	1 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	1,542,131	77	\$ 311,109	\$ 308,619	9,834	\$ 1,984	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	9,834	9	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	9,834	13	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	9,834	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	9,834	130	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	9,834	809	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	9,834	452	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	9,834	20	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	9,834	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	9,834	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	9,834	60,500	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	9,834	2,270	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	9,834	160	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	9,834	18,494	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	9,834	66	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	9,834	19	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	9,834	1,700	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	9,834	460	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	9,834	7,517	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	9,834	2,657	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	9,834	3,198	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	9,834	163	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	9,834	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	9,834	290	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 100,911	25

Facility Name & ID Number Shawnee Rose Care Center# 0050351 Report Period Beginning: 1/1/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Midwest Health Properties, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	89,235	7	\$	9,834	\$	1
2	2	Food	Resident Days	89,235	7		9,834		2
3	3	Housekeeping	Resident Days	89,235	7		9,834		3
4	4	Laundry	Resident Days	89,235	7		9,834		4
5	5	Utilities	Resident Days	89,235	7		9,834		5
6	6	Maintenance	Resident Days	89,235	7		9,834		6
7	7	Mgmt. Allocation of Benefits	Resident Days	89,235	7		9,834		7
8	10	Nursing and Medical Records	Resident Days	89,235	7		9,834		8
9	10A	Therapy	Resident Days	89,235	7		9,834		9
10	15	Mgmt. Allocation of Benefits	Resident Days	89,235	7		9,834		10
11	17	Administrative	Resident Days	89,235	7		9,834		11
12	19	Professional Services	Resident Days	89,235	7	7,036	9,834	775	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	89,235	7		9,834		13
14	21	Clerical and General Office	Resident Days	89,235	7	13,414	9,834	1,478	14
15	22	Employee Benefits & Payroll	Resident Days	89,235	7		9,834		15
16	24	Travel and Seminar	Resident Days	89,235	7		9,834		16
17	25	Other Admin. Staff Transport.	Resident Days	89,235	7		9,834		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	89,235	7		9,834		18
19	27	Mgmt. Allocation of Benefits	Resident Days	89,235	7		9,834		19
20	30	Depreciation	Resident Days	89,235	7		9,834		20
21	32	Interest	Resident Days	89,235	7		9,834		21
22	33	Real Estate Taxes	Resident Days	89,235	7		9,834		22
23	34	Rent-Facility and Grounds	Resident Days	89,235	7		9,834		23
24	35	Rent-Equipment & Vehicles	Resident Days	89,235	7		9,834		24
25	TOTALS					\$ 20,450	\$	\$ 2,253	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	Interest Only	3/1/09	\$ 1,255,464	\$ 1,255,464	3/1/12	0.0600	\$ 76,374	1								
2	Ford Credit		X	Van	\$651.36	11/1/10	27,601	20,372	10/31/15	0.0500	1,413	2								
3											(656)	3								
4											3,198	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$651.36		\$ 1,283,065	\$ 1,275,836			\$ 80,329	9								
B. Non-Facility Related*																				
10											Amortization of Loan Costs	2,471	10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$			\$ 2,471	14								
15	TOTALS (line 9+line14)						\$ 1,283,065	\$ 1,275,836			\$ 82,800	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2010 report.			\$	23,100 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.)	2010		\$	24,304 2
3.	Under or (over) accrual (line 2 minus line 1).			\$	1,204 3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	25,080 4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation				163
	TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	26,447 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2006	<u>20,380</u>	<u>8</u>		
	2007	<u>19,171</u>	<u>9</u>		
	2008	<u>21,688</u>	<u>10</u>		
	2009	<u>22,414</u>	<u>11</u>		
	2010	<u>24,304</u>	<u>12</u>		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Rose Care Center COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0050351

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-2-656-01</u>	<u>Long-Term Care Facility</u>	\$ <u>22,326.26</u>	\$ <u>22,326.26</u>
2. <u>06-2-655-10</u>	<u>Long-Term Care Facility</u>	\$ <u>1,977.66</u>	\$ <u>1,977.66</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>24,303.92</u></u>	\$ <u><u>24,303.92</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>108,900</u>	<u>2009</u>	<u>\$ 140,000</u>	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	\$ 105,000
5										
6										
7										
8										
	Improvement Type**									
9	A/C Unit		2009		4,500		5	900	900	2,250
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28	Land Improvements Booked									
29	Building Booked					42,000			(42,000)	
30	Building Improvement Booked					643			(643)	
31										
32										
33	2011-Home Office Allocation-Land Improvements				437			28	28	
34	2011-Home Office Allocation-Building Improvements				4,681			112	112	
35										
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,059,618		42,643		43,040	
						397	107,250	

**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	\$ 214,148	\$ 30,592	\$ 21,415	\$ (9,177)	10 yrs.	\$ 53,537	71
72	Current Year Purchases	2,554	243	128	(115)	10 yrs.	128	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,517	2,517			74
75	TOTALS	\$ 216,702	\$ 30,835	\$ 24,060	\$ (6,775)		\$ 53,665	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	\$ 5,909	\$ 5,909	\$	5 yrs.	\$ 8,863	76
77										77
78										78
79										79
80	TOTALS			\$ 29,543	\$ 5,909	\$ 5,909	\$		\$ 8,863	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)	\$ 1,445,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,387	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,009	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,378)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 169,778	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	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

0050351

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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: \$ 16,924 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

* 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
0050351**

Period Beginning	<u>1/1/2011</u>
Period End	<u>12/31/2011</u>

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 12,597
Dishwasher	708
Laundry Equipment	-
Copier	3,329
Home Office Allocation	<u>290</u>
	<u>16,924</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$	4,174	\$ 62,610	\$	4,174	\$ 62,610	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,655	39,819		2,655	39,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,595	53,921		3,595	53,921	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				39,331		39,331	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			\$	10,424	\$ 156,350	\$ 39,331	10,424	\$ 195,681	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Shawnee Rose Care Center**# **0050351**Report Period Beginning: **1/1/2011**

Ending:

12/31/2011**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2011**

(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	\$ 800	\$ 800	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	527,119	527,119	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,113	19,113	6
7	Other Prepaid Expenses	4,183	4,183	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 551,215	\$ 551,215	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	140,000	140,000	13
14	Buildings, at Historical Cost	1,050,000	1,054,681	14
15	Leasehold Improvements, at Historical Cost	4,500	4,937	15
16	Equipment, at Historical Cost	246,245	246,245	16
17	Accumulated Depreciation (book methods)	(214,217)	(169,778)	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 (spec Loan Costs)	412	412	22
23	Other(specify): A/R-Prior Owner	52,893	52,893	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,279,833	\$ 1,329,390	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,831,048	\$ 1,880,605	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,525,289	\$ 1,525,289	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,162	40,162	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,017	3,017	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,080	25,080	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Payroll Withholdings	37,853	37,853	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,631,401	\$ 1,631,401	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	20,372	20,372	39
40	Mortgage Payable	1,255,464	1,255,464	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)	\$ 1,275,836	\$ 1,275,836	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,907,237	\$ 2,907,237	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,076,189)	\$ (1,026,632)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,831,048	\$ 1,880,605	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (810,155)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (810,153)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(266,036)	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)	\$ (266,036)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,076,189)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shawnee Rose Care Center# 0050351Report Period Beginning: 1/1/2011Ending: 12/31/2011

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,168,549	1
2	Discounts and Allowances for all Levels	(115,115)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,053,434	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	242,407	6
7	Oxygen	456	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 242,863	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	1,920	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,031	20
21	Other Medical Services	8,780	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 73,141	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	656	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 656	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	296	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,370,390	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	349,152	31
32	Health Care	613,832	32
33	General Administration	374,236	33
B. Capital Expense			
34	Ownership	202,563	34
C. Ancillary Expense			
35	Special Cost Centers	59,413	35
36	Provider Participation Fee	37,230	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,636,426	40
41	Income before Income Taxes (line 30 minus line 40)**	(266,036)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (266,036)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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**

0050351

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	2,080	2,080	\$ 47,768	\$ 22.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,172	2,172	38,795	17.86	3
4	Licensed Practical Nurses	7,008	7,158	105,422	14.73	4
5	CNAs & Orderlies	20,174	20,887	182,602	8.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,692	1,728	17,591	10.18	9
10	Activity Assistants	129	129	1,093	8.47	10
11	Social Service Workers	529	616	7,571	12.29	11
12	Dietician					12
13	Food Service Supervisor	1,872	1,952	20,103	10.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,158	9,437	78,738	8.34	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	29,397	14.13	17
18	Housekeepers	5,361	5,570	48,753	8.75	18
19	Laundry	3,136	3,296	27,417	8.32	19
20	Administrator	2,080	2,080	60,500	29.09	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 C: <u>Care Plan Coord</u>	1,403	1,403	24,386	17.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	58,874	60,588	\$ 690,136 *	\$ 11.39	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			35	
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	891	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				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)		\$ 12,891		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Shawnee Rose Care Center**

0050351

Report Period Beginning: **1/1/2011**

Ending: **12/31/2011**

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						
Elizabeth Dunn	Administrator	0	\$ 60,500	Workers' Compensation Insurance	\$ 20,486	IDPH License Fee	\$ 3,980						
				Unemployment Compensation Insurance	18,856	Advertising: Employee Recruitment	387						
				FICA Taxes	47,266	Health Care Worker Background Check							
				Employee Health Insurance	170,996	(Indicate # of checks performed)							
				Employee Meals		Patient Background Checks	64 649						
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	458						
				Employee Relations	137	Miscellaneous Dues & Subscriptions	402						
				Life Insurance	32								
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 60,500	TOTAL (agree to Schedule V, line 22, col.8)			\$ 257,773	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,811			
(List each licensed administrator separately.)								Less: Public Relations Expense		(225)			
B. Administrative - Other							Non-allowable advertising		()				
Description			Amount				Yellow page advertising		()				
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 70,800										
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 70,800	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**						
(Attach a copy of any management service agreement)				Description			Line #	Amount	Description		Amount		
C. Professional Services													
Vendor/Payee	Type		Amount										
E-Health Data Solutions	Computer Services		\$ 3,485							Out-of-State Travel		\$	
Clearwave Communications	Computer Services		787										
Frontier	Computer Services		240	N/A						In-State Travel			
Mediacom	Computer Services		692										
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,204	TOTAL			\$				Seminar Expense		
(If total legal fees exceed \$5,000, attach copy of invoices.)										Home Office Allocation		19	
										Entertainment Expense		()	
										TOTAL (agree to Sch. V, line 24, col. 8)		\$ 19	

* Attach copy of IMRF notifications

**See instructions.

Shawnee Rose Care Center

0050351

Period Beginning 1/1/2011

Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,204

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	2
Henry County Recorder	Legal	
Ginoli & Company	Accountants	1,091
Miscellaneous Vendors	Computer Services	26
Advanced Answers on Demand	Computer Services	1,317
Access 2 Go	Computer Services	130
Kemper Technology	Computer Services	60
MediFax	Computer Services	20
VisionShare	Computer Services	93
Advanced System Design	Computer Services	121
Simple LTC	Computer Services	152
Optimizer Systems	Other Prof Fees	15
Clifton Gunderson	Other Prof Fees	5
Mike Miller	Other Prof Fees	7
OIC Group	Other Prof Fees	2
All Scripts	Other Prof Fees	4

Total (agree to Schedule V, line 19, column 8)		<u>8,249</u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,230
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? N/A 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. \$ 1,920
- (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. \$ 0
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? N/A**
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 & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.