

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road Champaign 61821
Number City Zip Code

County: Champaign

Telephone Number: (217) 356-5164 Fax # (217) 356-7873

HFS ID Number:

Date of Initial License for Current Owners: 08/15/1989

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c)(3)

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Joe Guillory Telephone Number: (859) 317-4040
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 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Kylie Waters Whipple
(Title) Vice President of Finance - Exceptional Living Centers

Paid
Preparer

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

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

Facility Name & ID Number Swann Special Care Center# 0035485 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 bedsN/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		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>45,018</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>45,018</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>42,374</u>	<u>732</u>	<u>160</u>	<u>43,266</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,374</u>	<u>732</u>	<u>160</u>	<u>43,266</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.11%

D. How many bed-hold days during this year were paid by the Department?

381 (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?

YesG. 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 08/15/1989

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

YES ☒Date 08/15/1989NO ☐

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

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

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

YES

X

NO

Note: Unamortized Bond Acquisition Costs not related to patient care of \$73,387 have been included on line 18 of the Balance Sheet.

Period Beginning: 07/01/2011 Ending: 06/30/2012

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	233,010	20,045	45,199	298,254	926	299,180	(73,052)	226,128			1
2	Food Purchase		130,822		130,822		130,822		130,822			2
3	Housekeeping		37,178	137,583	174,761		174,761		174,761			3
4	Laundry	5,572	9,636	98,162	113,370		113,370		113,370			4
5	Heat and Other Utilities			85,421	85,421		85,421	(6,094)	79,327			5
6	Maintenance	62,404	13,121	38,618	114,143	1,168	115,311		115,311			6
7	Other (specify):*											7
8	TOTAL General Services	300,986	210,802	404,983	916,771	2,094	918,865	(79,146)	839,719			8
	B. Health Care and Programs											
9	Medical Director			45,600	45,600		45,600		45,600			9
10	Nursing and Medical Records	3,018,029	320,196	37,941	3,376,166	(44,363)	3,331,803		3,331,803			10
10a	Therapy	4,712	8,430	153,419	166,561		166,561		166,561			10a
11	Activities	209,016	1,570	738	211,324		211,324		211,324			11
12	Social Services	1,761		1,140	2,901		2,901		2,901			12
13	CNA Training					48,575	48,575		48,575			13
14	Program Transportation	63,083	39	39,801	102,923		102,923		102,923			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,296,601	330,235	278,639	3,905,475	4,212	3,909,687		3,909,687			16
	C. General Administration											
17	Administrative	88,169		251,334	339,503	(168,313)	171,190	(13,454)	157,736			17
18	Directors Fees											18
19	Professional Services			712,709	712,709	(335,337)	377,372	(245,315)	132,057			19
20	Dues, Fees, Subscriptions & Promotions			51,383	51,383	62,019	113,402	(40,453)	72,949			20
21	Clerical & General Office Expenses	93,338	15,034	58,847	167,219	349,639	516,858	(5,444)	511,414			21
22	Employee Benefits & Payroll Taxes			828,279	828,279	13,663	841,942		841,942			22
23	Inservice Training & Education			10,215	10,215	(1,444)	8,771		8,771			23
24	Travel and Seminar			9,683	9,683	19,013	28,696	(545)	28,151			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,705	53,705	8,284	61,989		61,989			26
27	Other (specify):* Indigent Care			42,466	42,466		42,466	(42,466)				27
28	TOTAL General Administration	181,507	15,034	2,018,621	2,215,162	(52,476)	2,162,686	(347,677)	1,815,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,779,094	556,071	2,702,243	7,037,408	(46,170)	6,991,238	(426,823)	6,564,415			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			206,434	206,434	9,322	215,756	(16,234)	199,522			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			454,785	454,785	18,019	472,804	(94,913)	377,891			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			979	979	18,774	19,753		19,753			34
35	Rent-Equipment & Vehicles			10,674	10,674	496	11,170		11,170			35
36	Other (specify):* Amortization			13,404	13,404	771	14,175	(2,480)	11,695			36
37	TOTAL Ownership			686,276	686,276	47,382	733,658	(113,627)	620,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			23,989	23,989		23,989		23,989			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			446,566	446,566		446,566		446,566			42
43	Other (specify):* Edu/Day Training	1,231,706	9,638	412,689	1,654,033	(1,212)	1,652,821		1,652,821			43
44	TOTAL Special Cost Centers	1,231,706	9,638	883,244	2,124,588	(1,212)	2,123,376		2,123,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,010,800	565,709	4,271,763	9,848,272		9,848,272	(540,450)	9,307,822			45

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

Swann Special Care Center
Schedule V Supplemental Schedule
"Other" Amounts in excess of \$1,000
Lines 36 and 43

Section D	Col. 3
Other Expense (Line 36)	Other
Amortization of Bond Issue Costs	13,404
TOTAL	13,404

Section E	Col. 1	Col. 2	Col. 3
Other Expense (Line 43)	Salary/Wage	Supplies	Other
Education	501,874	5,402	164,721
Day Training	729,832	4,235	247,968
TOTAL	1,231,706	9,637	412,689

Swann Special Care Center
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION	INCREASE	DECREASE	SCH V LINE.COL
1 <u>Reclassification of Hoosier Care Group Expenses:</u>			
Administrative (Rel. Party Group Expense Allocation)		(251,334)	17.5
Heat & Other Utilities	926		5.5
Maintenance	850		6.5
Administration	69,567		18.5
Professional Services	66,511		19.5
Dues, Fees, Subscriptions & Promotions	48,530		20.5
Clerical & General Office Expenses	17,134		21.5
Employee Benefits & Payroll Taxes	10,225		22.5
Travel & Seminar	3,492		24.5
Insurance - Prop.Liab.Malpractice	(55)		26.5
Depreciation	345		30.5
Interest	18,019		32.5
Rent - Facility & Grounds	1,440		34.5
Rent - Equipment	125		35.5
Other (Amort)	771		36.5
2 <u>Reclassification of ELC Corporate Expenses</u>			
Professional Services (Rel. Party Mgmt. Fee)		(649,200)	19.5
Maintenance	318		6.5
Professional Services	9,668		19.5
Dues, Fees, Subscriptions & Promotions	13,489		20.5
Clerical & General Office Expenses	332,505		21.5
Employee Benefits & Payroll Taxes	3,438		22.5
Inservice Training & Education	1,556		23.5
Travel & Seminar	15,521		24.5
Insurance - Prop.Liab.Malpractice	8,339		26.5
Depreciation	8,977		30.5
Rent - Facility & Grounds	17,334		34.5
Rent - Equipment	371		35.5

3 Reclassification of C.N.A. Training Expenses

C.N.A. Training	48,575		13.5
Nursing & Medical Records		(44,363)	10.5
Other - Edu/Day Training		(1,212)	43.5
Inservice Training & Education		(3,000)	23.5

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

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	(73,052)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,094)	5		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
10	Interest and Other Investment Income	(11,172)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(83,741)	32		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	(977)	20		18
19	Entertainment	(485)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,631)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,466)			24
25	Fund Raising, Advertising and Promotional	(36,948)	20		25
	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 attached	(26,746)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (289,312)		\$	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)	(251,138)	17, 19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (251,138)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (540,450)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Swann Special Care Center

ID# 0035485

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Unallowable Fundraising Expense	\$ (960)	21	1
2	Amortization of Bond Acq Costs not Facility-Related	(2,480)	36	2
3	Unallowable Auto Expense	(60)	24	3
4	Unallowable Lobbying Portion of ILHCA Dues	(2,528)	20	4
5	Miscellaneous Income	(4,484)	21	5
6	Unallowable Auto Expense (Depr)	(16,234)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(26,746)		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
Hoosier Care, Inc.	100%	Walter Lawson Children's Home	Loves Park, IL	Medical Rehabilitation	Lexington, KY	Mgmt. Co.
		Exceptional Care & Training Center	Sterling, IL			
		Vernon Manor Children's Home	Wabash, IN	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Richland-Bean Blossom Health Care Center	Ellettsville, IN			
		Exceptional Living Centers of Brazil	Brazil, IN			
		Randolph Nursing Home	Winchester, IN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Group Overhead	\$ 251,334	Hoosier Care, Inc.	100.00%	\$ 237,880	\$ (13,454)	1
2	V				Note: Please see Schedule VIII for Allocation of Col. 7 Amt				2
3	V								3
4	V	19	Rel. Party Management Fee	649,200	Medical Rehabilitation Centers, LLC	25.00%	411,516	(237,684)	4
5	V				dba Exceptional Living Centers				5
6	V				Hoosier Care owns 25% of the beneficial interests of MRC				6
7	V				Note: Please see Schedule VIII for Allocation of Col. 7 Amt				7
8	V								8
9	V	17	Hoosier Care Investments, LLC	69,567	Hoosier Care, Inc. is a member of Hoosier Care Investments, LLC., a Not-for-Profit company which provides oversight, corporate governance and administrative services for all of Hoosier Care's affiliated facilities.	N/A	69,567		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 970,101			\$ 718,963	\$ * (251,138)	14

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	John Foos	Board Member	Governance	0%					\$		1
2	John Gillmor	Board Member	Governance	0%							2
3	Bruce Hutson	Board Member	Governance	0%							3
4	Jo Anne Corbitt	Board Member	Governance	0%							4
5	Douglas Smith	Board Member	Governance	0%							5
6	Lew Wood, Jr.	Board Member	Governance	0%							6
7	Stephen Wood	Board Member	Governance	0%							7
8	Fees are paid by Hoosier Care to Hoosier Care Investments, LLC (HCI), which go toward, among other things solely within the										8
9	control of HCI, fees for members of the Boards of Directors of HCI affiliated facilities, Walter Lawson Children's Home										9
10	being only one of many. The total amount included on Line 17 of this Cost Report, through the Hoosier Care allocation of										10
11	indirect costs, is disclosed here. Amounts paid by other facilities are shown on Page 7.1										11
12								Fees	69,567	17.8	12
13								TOTAL	\$ 69,567		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

VII. RELATED PARTIES (continued)

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

* 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.

Amounts paid for Home Office Board / Administration Fees by other Nursing Homes

Walter Lawson Children's Home	61,504
Swann Special Care Center	69,567
Exceptional Care & Training Center	46,352
Vernon Manor Children's Home	44,860
Exceptional Living Center of Brazil	52,361
Richland-Bean Blossom Health Care	34,729
Randolph Nursing Home	36,103

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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 Hoosier Care, Inc.
Street Address 1050 Chinoe Road, Suite 350
City / State / Zip Code Lexington, KY 40502
Phone Number (859) 255-0075
Fax Number (859) 281-5150

	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	5	Heat & Other Utilities	Direct Costs	48,917,933	7	\$ 4,598	\$	9,850,328	\$ 926	1
2	6	Maintenance	Direct Costs	48,917,933	7	4,220		9,850,328	850	2
3	17	Administration	Direct Costs	48,917,933	7	345,476		9,850,328	69,567	3
4	19	Professional Services	Direct Costs	48,917,933	7	330,303	87,296	9,850,328	66,511	4
5	20	Dues, Fees, Subscriptions	Direct Costs	48,917,933	7	241,007		9,850,328	48,530	5
6	21	Clerical & General Office Exp	Direct Costs	48,917,933	7	85,092	66,386	9,850,328	17,134	6
7	22	Emp. Benefits & Payroll Tax	Direct Costs	48,917,933	7	50,777		9,850,328	10,225	7
8	24	Travel & Seminar	Direct Costs	48,917,933	7	17,342		9,850,328	3,492	8
9	26	Insurance	Direct Costs	48,917,933	7	(273)		9,850,328	(55)	9
10	30	Depreciation	Direct Costs	48,917,933	7	1,712		9,850,328	345	10
11	32	Interest Expense	Direct Costs	48,917,933	7	89,484		9,850,328	18,019	11
12	34	Rent - Facility	Direct Costs	48,917,933	7	7,150		9,850,328	1,440	12
13	35	Rent - Equipment	Direct Costs	48,917,933	7	623		9,850,328	125	13
14	36	Other (Amortization)	Direct Costs	48,917,933	7	3,830		9,850,328	771	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,181,341	\$ 153,682		\$ 237,880	25

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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 Medical Rehabilitation Centers, LLC
Street Address 1050 Chinoe Road, Suite 350
City / State / Zip Code Lexington, KY 40502
Phone Number (859) 255-0075
Fax Number (859) 281-5150

	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	6	Maintenance	Direct Costs	89,405,466	15	\$ 2,889	\$	9,850,328	\$ 318	1
2	19	Professional Services	Direct Costs	89,405,466	15	87,754		9,850,328	9,668	2
3	20	Dues, Fees, Subscriptions	Direct Costs	89,405,466	15	122,430		9,850,328	13,489	3
4	21	Clerical & General Office	Direct Costs	89,405,466	15	3,017,945	3,017,945	9,850,328	332,505	4
5	22	Employee Benefits & Payroll Tax	Direct Costs	89,405,466	15	31,204		9,850,328	3,438	5
6	23	Inservice Training & Education	Direct Costs	89,405,466	15	14,123		9,850,328	1,556	6
7	24	Travel & Seminar	Direct Costs	89,405,466	15	140,877		9,850,328	15,521	7
8	26	Insurance	Direct Costs	89,405,466	15	75,692		9,850,328	8,339	8
9	30	Depreciation	Direct Costs	89,405,466	15	81,475		9,850,328	8,977	9
10	34	Rent - Facility & Grounds	Direct Costs	89,405,466	15	157,333		9,850,328	17,334	10
11	35	Rent - Equipment	Direct Costs	89,405,466	15	3,367		9,850,328	371	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	TOTALS					\$ 3,735,089	\$ 3,017,945		\$ 411,516	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	Ill. Health Finance Auth.		X	Purchase of Facility	Varies	07/08/99	\$ 5,710,000	\$ 4,910,000	06/01/34	0.0713	\$ 354,025	1	
2	Ill. Health Finance Auth.		X	Purchase of Facility	Varies	07/08/99	260,000	150,000	06/02/19	0.0105	17,019	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Group Allocation		X	Working Capital	Varies	10/27/11	5,000,000	Varies	10/27/14	Varies	18,019	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 10,970,000	\$ 5,060,000			\$ 389,063	9	
	B. Non-Facility Related*												
10	Group Debt Allocation		X	Alloc of Group Debt / Former F	Varies	07/08/99	1,243,913	1,141,287	Varies	Varies	83,741	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 1,243,913	\$ 1,141,287			\$ 83,741	14	
15	TOTALS (line 9+line14)						\$ 12,213,913	\$ 6,201,287			\$ 472,804	15	

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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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. 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.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2007 8 2008 9 2009 10 2010 11 2011 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
			14 PLUS APPEAL COST FROM LINE 5 \$	14
			15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

Note: This facility became exempt from Property Taxes starting on 1/1/1996

- 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Swann Special Care Center	COUNTY	Champaign
---------------	---------------------------	--------	-----------

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)		(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	N/A - TAX EXEMPT			\$	\$
2.				\$	\$
3.				\$	\$
4.				\$	\$
5.				\$	\$
6.				\$	\$
7.				\$	\$
8.				\$	\$
9.				\$	\$
10.				\$	\$
TOTALS				\$	\$

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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 25,257

B. General Construction Type: Exterior Block & Brick

Frame Wood

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).

None.

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF / PED	89,603	1989	\$ 538,000	1
2					2
3	TOTALS	89,603		\$ 538,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	87		1989	1978	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275	\$	\$ 1,630,635	4
5	9			1993	319,955	10,665	30	10,665		225,177	5
6	8			1996	N/A						6
7	8			2000	157,933	5,264	30	5,264		61,857	7
8	11			2004	N/A						8
	Improvement Type**										
9	PAINT & PANELS			1989	1,308		3			1,308	9
10	BLINDS			1990	384		3			384	10
11	FIRE DOORS			1990	2,751		10			2,751	11
12	STORM WINDOW			1991	4,225		10			4,225	12
13	FIRE DOORS			1991	3,675		10			3,675	13
14	ROTOTECH COMPRESSOR - ROG			1991	1,035		10			1,035	14
15	CARPETING - TILE SPECIALT			1991	220		10			220	15
16	SPRINKLER/FIRE SYSTM-MCDA			1991	696		10			696	16
17	SPRINKLER/EXIT DEVICES OD			1992	3,162		10			3,162	17
18	DAMPER - ROGERS SUPPLY			1992	674		10			674	18
19	FIRE ALARM SYSTEM - AI AL			1992	1,945		10			1,945	19
20	WATER HEATER			1992	1,998		7			1,998	20
21	ROOFING			1992	3,900		10			3,900	21
22	VOLTAGE RELAY			1993	1,875		10			1,875	22
23	SPRINKLER SYSTEM			1993	14,460		10			14,460	23
24	WALL COVERING			1993	3,190		10			3,190	24
25	WALL PAPERING			1993	3,000		10			3,000	25
26	BLINDS WITH VALANCE			1993	2,395		10			2,395	26
27	CARPET AND RUBBER BASE			1993	2,848		10			2,848	27
28	SHED			1993	5,990		10			5,990	28
29	REPLACE SIDING			1993	575		10			575	29
30	STAIN NEW SHED			1993	1,248		10			1,248	30
31	REMODELING IN TEAM ROOMS			1993	9,405		10			9,405	31
32	PLEXIGLASS FOR DOORS & WA			1993	714		10			714	32
33	RESURFACE PARKING LOT			1993	19,115		10			19,115	33
34	FIRE DOORS, CLOSETS, TILE			1993	5,225		10			5,225	34
35	ARCHITECTURAL RENOVATION			1993	855		10			855	35
36	INSTALL ALARM & NURSE CAL			1994	688		10			688	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 Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	HEAT PUMP	1994	\$ 2,017	\$	10	\$	\$	\$ 2,017	37
38	PAVING FOR NEW SIGN	1994	680		10			680	38
39	LABOR FOR LAYING BRICK -	1994	1,000		10			1,000	39
40	SIGN FOR DEDICATION	1994	325		10			325	40
41	SIGN AND GRANITE PIECES	1994	1,300		10			1,300	41
42	MATERIALS FOR LEASEHOLD I	1995	7,858		3			7,858	42
43	HOODS, FANS, ANSUL SYSTEM	1995	2,500		10			2,500	43
44	WORK FOR EXHAUST FAN & HO	1995	3,995		10			3,995	44
45	DAY ROOM ADDITION	1995	3,337		10			3,337	45
46	REPLACE WATER HEATER	1995	3,750		10			3,750	46
47	DAY ROOM ADDITION SUPPLIE	1995	1,926		10			1,926	47
48	WALK-IN COOLER	1995	3,334		10			3,334	48
49	ADD NURSE CALL SYSTEM	1996	1,198		10			1,198	49
50	SHED	1996	2,034		10			2,034	50
51	SUPPLIES FOR LEASEHOLD IM	1996	3,091		3			3,091	51
52	CONSTRUCTION PROJECTS	1996	180,928	9,046	20	9,046		147,003	52
53	AIR CONDITIONER COMPRESSO	1996	1,208		10			1,208	53
54	INSTALL NURSE CALL SYSTEM	1996	1,530		10			1,530	54
55	TILE & ADHESIVE	1996	1,227		10			1,227	55
56	INSTALL NEW DRAIN PIPES	1996	2,190		10			2,190	56
57	REMOVE CONCRETE TO REPL P	1996	575		10			575	57
58	ADHESIVE LINOLEUM	1996	686		10			686	58
59	CONSTRUCT SCREENS,WHEELCH	1996	1,420		3			1,420	59
60	CONSTRUCT SHELVING,BEDS,S	1996	2,964		3			2,964	60
61	INSTALL EXIT HARDWARE ON	1997	874		10			874	61
62	INSTALL NEW DISPOSAL	1997	1,069		10			1,069	62
63	DAY TRAINING LEASE IMPROV	1998	3,911		4			3,911	63
64	FRP BOARD, CAP, SHELF BRA	1998	167		4			167	64
65	REPLACE FOUR-DOOR GLASS	1998	520		10			520	65
66	REPLACE UNDERGROUND FUEL	1998	9,223	461	20	461		6,302	66
67	PARTITION WALL:KITCHEN/DI	1998	595		8			595	67
68	CONVERT 2 CLASSRMS TO RES	1998	15,258		10			15,258	68
69	REPLACE 2 ROOFTOP HVAC UN	1998	17,650		10			17,650	69
70	TOTAL (lines 4 thru 69)		\$ 3,447,782	\$ 81,712		\$ 81,712	\$	\$ 2,258,718	70

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	
1	Totals from Page 12A, Carried Forward		\$ 3,447,782	\$ 81,712		\$ 81,712	\$	\$ 2,258,718	1
2	VENT DAMPER:HOT WATER HEA	1998	740		10			740	2
3	REMODEL PROJ:2410 SPRINGF	1998	33,764		4			33,764	3
4	ELECTRICAL SRVC:MOVE SWIT	1999	141		8			141	4
5	SECURITY DOOR & CLOSERS	1999	520		10			520	5
6	COMBUSTION MOTOR/FAN ON H	1999	1,155		10			1,155	6
7	REMOVE/RPLCE HOT WATER HE	1999	3,000		10			3,000	7
8	BAL:INSTALL HOT WATER HEA	1999	595		10			595	8
9	FRP PANEL DIVIDERS	1999	513		5			513	9
10	RE-SURFACE PARKING LOT	1999	2,350	157	15	157		2,024	10
11	REPLACE COMPRESSOR ON FRE	1999	635		10			635	11
12	REPLACE BATHROOM FLOORS	1999	594	40	15	40		508	12
13	REPLACE RELAY ON GENERATO	1999	2,782		10			2,782	13
14	DEPOSIT ON STORAGE BARN	1999	120	5	25	5		61	14
15	BALANCE DUE ON STORAGE BA	1999	1,045	42	25	42		533	15
16	REPL THRU THE WALL HEAT P	1999	1,525		10			1,525	16
17	NEW TEMPERING VALVE-HOT W	2000	629		10			629	17
18	REPL TIMER/STARTER-EMERG	2000	2,153		10			2,153	18
19	INTERIOR ENERGY EFFICIENT	2000	15,090	755	20	755		9,306	19
20	PARTIAL PMT-INSTALL ALARM	2000	2,000		5			2,000	20
21	BALANCE-INSTALL ALARM SYS	2000	2,730		5			2,730	21
22	INSTALL CLINICAL SINK.	2000	3,030		5			3,030	22
23	INSTALL DOORS AT KENWOOD	2000	4,028	269	15	269		3,223	23
24	REPLACE GATE VALVE/INSTAL	2000	6,005	400	15	400		4,737	24
25	REPLACE CEILING TILE, PIP	2000	674		10			674	25
26	STONEBROOK REMODELING PR	2000	138,235		5			138,235	26
27	MATERIALS TO TILE BATHROO	2000	784		10			784	27
28	STONEBROOK AWNING.	2001	15,560		5			15,560	28
29	INSTALL BOOSTER PUMP.	2001	1,995	133	15	133		1,529	29
30	INSTALL TILE IN BATHROOM	2001	825	55	15	55		632	30
31	STONEBROOK TELEPHONE SYS	2001	1,668		5			1,668	31
32	NEW FLOOR DRAINS IN SHOWE	2001	3,180	212	15	212		2,438	32
33	COMP. ED. ROOM AT STONEYB	2001	2,431		5			2,431	33
34	TOTAL (lines 1 thru 33)		\$ 3,698,278	\$ 83,778		\$ 83,778	\$	\$ 2,498,973	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	
1	Totals from Page 12B, Carried Forward		\$ 3,698,278	\$ 83,778		\$ 83,778	\$	\$ 2,498,973	1
2	STONEBROOK SHELVES -INST	2001	516		5			516	2
3	REPLACE REVERSING VALVE &	2001	599		10			599	3
4	REPLACEMENT PARTS FOR ROO	2001	662		10			662	4
5	TILE FOR BATHROOM	2001	1,854		10			1,854	5
6	SPRINKLER SYSTEMS RENOVAT	2001	760	51	15	51		557	6
7	INSTALL SHOWER DRAINS	2001	10,500	525	20	525		5,775	7
8	TILE TO REPLACE TUBS	2001	1,278	85	15	85		937	8
9	REWIRED AND REPLACED COMP	2001	1,404	12	10	12		1,404	9
10	REMODELING	2001	8,351		5			8,351	10
11	WATER HEATER VALVE	2001	876	22	10	22		876	11
12	REPLACED LAUNDRY PANEL	2001	1,179	79	15	79		845	12
13	REPLACE DOORS	2002	3,000		5			3,000	13
14	SECURITY SYSTEM	2002	3,165		5			3,165	14
15	INTERNET SET-UP-WIRING, C	2002	6,141	409	15	409		4,265	15
16	REMODELING	2002	8,351		5			8,351	16
17	ELECTRICAL LABOR-REMODELI	2002	1,425		5			1,425	17
18	CLASSROOM REMODEL	2002	5,978	399	10	399		5,978	18
19	REVISION OF SPRINKLER SYS	2002	501		5			501	19
20	FENCING	2002	674	56	10	56		674	20
21	INSTALL TWO SINKS	2002	3,561		5			3,561	21
22	THERMOSTATS WITH LOCKING	2002	1,371	91	15	91		929	22
23	RE-SEAL AND RE-STRIPE PAR	2002	2,810	281	10	281		2,810	23
24	CARPET AND INSTALLATION	2002	2,954	295	10	295		2,954	24
25	NEW MOTHER BOARD/ALARM SY	2002	1,490	149	10	149		1,478	25
26	INSTALL A/C ROOFTOP UNIT	2002	8,237	549	15	549		5,446	26
27	NEW 2ND ROOFTOP COMPRESSO	2002	762	51	15	51		500	27
28	INSTALLED NEW PHONE SYS.S	2002	2,735		5			2,735	28
29	INSTALL NEW PHONE/DAY TRA	2002	2,488		5			2,488	29
30	HEIGHT ADJ.SUPINE TUB	2002	8,469	847	10	847		8,116	30
31	REMODEDLING	2003	8,351		5			8,351	31
32	RELIEF VAVLES/BOOSTER HEA	2003	555	56	10	56		528	32
33	CENTRAL HEAT/AIR ROOFTOP	2003	5,180	345	15	345		3,281	33
34	TOTAL (lines 1 thru 33)		\$ 3,804,457	\$ 88,079		\$ 88,079	\$	\$ 2,591,885	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	
1	Totals from Page 12C, Carried Forward		\$ 3,804,457	\$ 88,079		\$ 88,079	\$	\$ 2,591,885	1
2	NEW TILE AND BASE FLOOR	2003	847	85	10	85		804	2
3	NEW HYDROTHERAPY TUB	2003	1,900	190	10	190		1,805	3
4	ELECTRIC WATER HEATER	2003	5,600	560	10	560		5,227	4
5	EXHAUST FAN	2003	525	53	10	53		477	5
6	Install dry pendent sprinkler in freezer	2003	675	68	10	68		602	6
7	Rooftop unit installed; heat/air wing 3	2003	10,910	727	15	727		6,485	7
8	60 X 94 Lami Glass	2003	839		7			839	8
9	REMODELING	2004	8,351		5			8,351	9
10	Install draining system in courtyard	2004	9,268		7			9,268	10
11	New Wing	2004	179,834	5,994	30	5,994		49,954	11
12	Drainage Sys for Courtyard	2004	501		7			501	12
13	Lift Pump for Drinking Fountain	2004	1,040		5			1,040	13
14	AC Compressor Roof Top Main Bldg	2004	1,403		5			1,403	14
15	HVAC Compressor - Office	2004	1,079		5			1,079	15
16	New Roof	2004	28,855	1,443	20	1,443		11,422	16
17	exhaust fan motor/thermostat for N. Wing	2005	787	79	10	79		571	17
18	roofing project-Wing 1,2,4 (23318.33+43166.67	2005	66,485	4,432	15	4,432		31,396	18
19	replace 8 vinyl windows	2006	668	67	10	67		423	19
20	Re-tile shower room	2006	10,714	714	15	714		4,405	20
21	Deposit for duro last roof	2006	10,000	667	15	667		4,000	21
22	Duro last roof - payment #2	2006	4,384	292	15	292		1,754	22
23	Compressor for a/c unit wing 2	2006	1,506	151	10	151		891	23
24	Replace kitchen ceiling tiles	2006	552	37	15	37		215	24
25	Laundry room walls replaced	2006	2,323	155	15	155		903	25
26	100 amp sub panel	2006	2,650	177	15	177		1,016	26
27	Re-tile shower room #10	2006	11,642	776	15	776		4,463	27
28	Parking lot/dumpster pad repaved	2006	8,073	807	10	807		4,575	28
29	Replace walls in dishwasher area	2006	7,477	498	15	498		2,783	29
30	Re-tile shower room #3	2006	11,642	776	15	776		4,333	30
31	Fence/dumpster enclosure	2006	2,750	275	10	275		1,513	31
32	Re-tile shower room #4	2006	11,642	776	15	776		4,269	32
33	Dedicated ground circuit & four outlets	2006	1,513	101	15	101		555	33
34	TOTAL (lines 1 thru 33)		\$ 4,210,891	\$ 107,979		\$ 107,979	\$	\$ 2,759,204	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	
1	Totals from Page 12D, Carried Forward		\$ 4,210,891	\$ 107,979		\$ 107,979	\$	\$ 2,759,204	1
2	Re-tile shower room #s 5,6,7	2007	12,746	850	15	850		4,532	2
3	Dedicated ground circuit for server	2007	2,400	160	15	160		840	3
4	Metal panels for school windows	2007	2,158	144	15	144		743	4
5	15 amp receptacles (4)	2007	780	52	15	52		269	5
6	Electrical outlets in family room	2007	1,222	81	15	81		421	6
7	Curb & guardrail around dumpster area	2007	2,400	240	10	240		1,240	7
8	Rpl motors on roof exhaust fans (7)	2007	2,667	267	10	267		1,311	8
9	Upgrade lighting system in education bldg	2007	6,501	433	15	433		2,095	9
10	Re-tile team 6 bathroom	2007	7,561	504	15	504		2,436	10
11	Remodel employee breakroom	2007	2,478	248	10	248		1,177	11
12	Wire breakroom & outlets for nurses station	2007	2,574	172	15	172		787	12
13	Window on east side of education bldg replace	2008	640	43	15	43		192	13
14	Rooftop heat exchange replaced	2008	2,463	246	10	246		1,088	14
15	Air curtain for laundry room	2008	1,195	119	10	119		518	15
16	Replace 2 doors in laundry area	2008	4,187	279	15	279		1,210	16
17	South & northwest heat exchangers replaced	2008	2,421	242	10	242		1,049	17
18	Plexiglass window pane replaced	2008	527	53	10	53		220	18
19	Remodel conf room (cabinets, counter, c-tiles	2008	2,536	254	10	254		1,014	19
20	Lift sunken sidewalks	2008	1,595	160	10	160		625	20
21	Blower motor for RTU #5	2008	1,019	102	10	102		391	21
22	Sprinklers in conference room reconfigured	2008	621	41	15	41		155	22
23	220 outlet for stove in multi-purpose room	2008	1,148	77	15	77		281	23
24	Addtnl outlets (4 ea.) in rooms 5,6,8,9,10	2008	7,625	508	15	508		1,822	24
25	220 outlet for stove in Paige II	2008	1,148	57	20	57		206	25
26	Anti-scald valve	2009	761	76	10	76		247	26
27	Drainage system for courtyard	2009	2,250	150	15	150		463	27
28	Compressor for a/c unit	2009	2,830	283	10	283		802	28
29	Induct air purifiers (8) and required electri	2009	3,638	364	10	364		940	29
30	Dialer for sprinkler system	2010	1,062	106	10	106		266	30
31	Dedicated electric panel for washing machines	2010	1,149	77	15	77		160	31
32	Ceiling tiles	2010	720	72	10	72		144	32
33	Blower motor for a/c unit	2010	1,207	121	10	121		241	33
34	TOTAL (lines 1 thru 33)		\$ 4,295,122	\$ 114,559		\$ 114,559	\$	\$ 2,787,085	34

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

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	
1	Totals from Page 12E, Carried Forward		\$ 4,295,122	\$ 114,559		\$ 114,559	\$	\$ 2,787,085	1
2	Condensor fan motors (2) for rooftop unit	2010	562	56	10	56		108	2
3	Emergency shut off for generator	2010	1,248	125	10	125		229	3
4	Outlets (24) in resident rooms	2010	12,618	841	15	841		1,472	4
5	Outlets in rooms 3b/1b/5a/6a/5b/6b	2010	8,280	552	15	552		828	5
6	Outlets in rooms 7a/7b/13/14/17/11b/12a/12b..	2011	13,800	920	15	920		1,303	6
7	Combustion blower & ignitor for hvac unit	2011	1,426	143	10	143		202	7
8	P-tac hvac units (3)	2011	1,797	180	10	180		225	8
9	Ignition module & gas valve on laundry waterh	2011	1,507	151	10	151		176	9
10	Compressor & blower wheel	2011	2,575	258	10	258		258	10
11	Compressor for east wing a/c unit	2011	2,085	209	10	209		209	11
12	P-tac hvac units (2)	2011	1,299	119	10	119		119	12
13	Sprinklers for ext eaves on west wing	2011	4,275	321	10	321		321	13
14	Tile floor & walls of bathrooms (3)	2011	19,854	772	15	772		772	14
15	Heat exchanger	2011	4,035	235	10	235		235	15
16	Network drops (32) for Paige II	2011	2,550	149	10	149		149	16
17	Rpl fire control panel	2011	743	43	10	43		43	17
18	Heat exchanger	2012	6,570	164	10	164		164	18
19	Renovate shower rooms #2/14/15	2012	19,501	217	15	217		217	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,399,846	\$ 120,012		\$ 120,012	\$	\$ 2,794,114	34

**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	\$290,062	\$50,786	\$50,786	\$	3-10	\$169,859	71
72	Current Year Purchases	47,354	5,008	5,008		3-7	5,008	72
73	Fully Depreciated Assets	806,345	12,994	12,994		3-10	806,345	73
74								74
75	TOTALS	\$1,143,761	\$68,788	\$68,788	\$		\$981,212	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	Patient Transportation	1998 Dodge Van	2008	\$7,000	\$1,400	\$1,400	\$	5	\$5,833	76
77										77
78										78
79										79
80	TOTALS			\$7,000	\$1,400	\$1,400	\$		\$5,833	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)	\$6,088,607	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$190,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$190,200	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,781,159	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	Vehicles in Excess of 1 Allowable	\$201,789	\$16,234	\$147,535	86
87					87
88					88
89					89
90					90
91	TOTALS	\$201,789	\$16,234	\$147,535	91

G. Construction-in-Progress

	Description	Cost	
92	Preliminary Design Work	\$NEEDED	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
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	Corporate Group Allocations		N/A		18,774			5
6								6
7	TOTAL				\$ 18,774			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 N/A

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: \$ 10,674 Description: See attached detailed Schedule 14.1
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u>/2013</u>	\$ _____
13.	<u>/2014</u>	\$ _____
14.	<u>/2015</u>	\$ _____

* 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.

XII. RENTAL COSTS

16. Rental Amount for movable equipment: \$11,170

Description: See below for detailed breakdown

(Attach a schedule detailing the breakdown of movable equipment)

Vendor	Description	Amount
OCE Imagistics Inc	Copier Lease	\$ 8,765.00
Pitney Bowes	Posting Machine	\$ 1,909.00

TOTAL SSCC	\$ 10,674
HOOSIER CARE & MRC GROUP ALLOCATIONS:	\$ 496
TOTAL LINE XII.B.16	\$ 11,170

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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA80

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)		16,738		16,738
4	Clinical Wages (b)		26,374		26,374
5	In-House Trainer Wages (c)		2,463		2,463
6	Transportation				
7	Contractual Payments		3,000		3,000
8	CNA Competency Tests				
9	TOTALS	\$	\$ 48,575	\$	\$ 48,575
10	SUM OF line 9, col. 1 and 2 (e)	\$	48,575		

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	33
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	33

(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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39.3	visits			6,400			6,400	5
6	Dental Care	39.3	visits			5,258			5,258	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			7,090	5,241		12,331	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			\$		\$ 18,748	\$ 5,241		\$ 23,989	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,013	\$	1
2	Cash-Patient Deposits	87,536		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,267)	2,821,465		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,318		6
7	Other Prepaid Expenses	43,128		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	(263,478)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,703,982	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,128,971		14
15	Leasehold Improvements, at Historical Cost	270,875		15
16	Equipment, at Historical Cost	1,366,257		16
17	Accumulated Depreciation (book methods)	(3,928,694)		17
18	Deferred Charges	294,889		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	583,788		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	531,192		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,785,278	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,489,260	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,076	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,536		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	344,964		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	37,347		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 742,923	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,201,287		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)	\$ 6,201,287	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,944,210	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (454,950)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,489,260	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (966,286)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (966,286)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	511,336	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)	\$ 511,336	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)	\$ (454,950)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 07/01/2011Ending: 06/30/2012

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	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,665,818	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,665,818	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	859,251	9
10	Other Government Grants	73,052	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 932,303	23
	D. Non-Operating Revenue		
24	Contributions	19,161	24
25	Interest and Other Investment Income***	11,172	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,333	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training</u>	1,728,725	28
28a	<u>Miscellaneous Income</u>	4,484	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,733,209	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,361,663	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	916,771	31
32	Health Care	3,905,475	32
33	General Administration	2,215,162	33
	B. Capital Expense		
34	Ownership	686,276	34
	C. Ancillary Expense		
35	Special Cost Centers	1,678,022	35
36	Provider Participation Fee	446,566	36
	D. Other Expenses (specify):		
37			37
38			38
39	<u>Other Expense</u>	2,055	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,850,327	40
41	Income before Income Taxes (line 30 minus line 40)**	511,336	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 511,336	43

	1	2	
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,377,116	44
45	Private Pay - Net Inpatient Revenue	267,952	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	20,750	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,665,818	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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	1,987	2,120	\$ 74,323	\$ 35.06	1
2	Assistant Director of Nursing	1,738	1,923	63,274	32.90	2
3	Registered Nurses	32,614	35,257	981,124	27.83	3
4	Licensed Practical Nurses	14,486	15,386	292,025	18.98	4
5	CNAs & Orderlies	112,304	120,265	1,566,487	13.03	5
6	CNA Trainees					6
7	Licensed Therapist	420	447	4,712	10.54	7
8	Rehab/Therapy Aides	3,574	3,805	40,797	10.72	8
9	Activity Director	1,819	2,053	38,912	18.95	9
10	Activity Assistants	16,991	18,329	170,104	9.28	10
11	Social Service Workers	35	38	1,761	46.34	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,151	49,171	22.86	13
14	Head Cook	12,850	13,922	181,835	13.06	14
15	Cook Helpers/Assistants			2,003		15
16	Dishwashers					16
17	Maintenance Workers	3,844	4,215	62,404	14.81	17
18	Housekeepers					18
19	Laundry	334	386	5,572	14.44	19
20	Administrator	1,934	2,156	88,169	40.89	20
21	Assistant Administrator					21
22	Other Administrative	4,037	4,500	63,083	14.02	22
23	Office Manager					23
24	Clerical	5,990	6,521	95,954	14.71	24
25	Vocational Instruction					25
26	Academic Instruction	22,685	24,851	425,915	17.14	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	15,070	16,562	258,582	15.61	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) <u>Day Training</u>	46,123	49,506	544,593	11.00	33
34	TOTAL (lines 1 - 33)	300,742	324,393	\$ 5,010,800 *	\$ 15.45	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		\$ 14,605	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		27,745	10.3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		6,863	10a.3	40
41	Occupational Therapy Consultant		64,960	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,075	76,857	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	20	1,140	12.3	45
46	Other(specify)				46
47					47
48	<u>IT & Cost Report Consulting</u>		13,733	21.3	48
49	TOTAL (lines 35 - 48)	1,095	\$ 205,903		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

Swann Special Care Center

0035485

Report Period Beginning:

07/01/2011

Page 21

Ending:

06/30/2012

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	
Kym Halberstadt	Administrator	0%	\$ 88,169	Workers' Compensation Insurance	\$ 101,721	IDPH License Fee	\$	
				Unemployment Compensation Insurance	66,534	Advertising: Employee Recruitment	3,335	
				FICA Taxes	280,812	Health Care Worker Background Check	1,604	
				Employee Health Insurance	345,162	(Indicate # of checks performed 53)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	36,948	
				Employee Benefits - Other	28,192	Illinois Healthcare Association	6,788	
				Employee Benefits - Retirement Plan	5,858	Other Dues, Fees, Subscriptions	2,708	
						Corporate/Group Allocation	62,019	
						Less: Unallowable Fees/Penalties/Dues	(3,505)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 88,169			Less: Public Relations Expense	(36,948)	
(List each licensed administrator separately.)						Non-allowable advertising	()	
B. Administrative - Other								
Description			Amount	Group/Corporate Allocations			13,663	
Group/Corporate Allocation			\$ 251,334					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 251,334	TOTAL (agree to Schedule V, line 22, col.8)			\$ 841,942	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Medical Rehabilitation Centers, LLC	Management Co.		\$ 649,200			\$	Out-of-State Travel	\$
Automated Data Processing	Payroll Processing Services		21,745					
Medical Rehabilitation Centers, LLC	Accounting Fees		9,633					
Bradley Arant Boult Cummings	Legal Fees		166				In-State Travel	9,138
DeWitt Ross & Stevens	Legal Fees		762					
Feldman Feldman & Assoc	Legal Fees		350					
Hinshaw & Culbertson	Legal Fees		6,146					
Smith Amundsen LLC	Legal Fees		509				Seminar Expense	
Stites & Harbison	Legal Fees		826					
Taft Stettinius & Hollister	Legal Fees		309					
Medical Rehabilitation Centers, LLC	Legal Fees		23,063				Group/Corporate Allocations	19,013
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 712,709	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 28,151
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
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?

Yes

If YES, give association name and amount.

ILHCA, \$6,788 (Gross before Adj.)

(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?

(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?

(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?

5

(6)

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

\$ 24,000

Line 10.2

(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.

(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.

\$ 446,566

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.

\$ None

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

Yes

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

\$ 0

(17)

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

Yes

Firm Name:

Reznick Group

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?

Yes

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