

		FOR BHF USE					

LL1

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: 0048611

Facility Name: Swansea Rehabilitation & Health Care Center

Address: 1405 North Second Street Swansea 62226
Number City Zip Code

County: St. Clair

Telephone Number: (618) 233-6625 Fax # (618) 233-5858

HFS ID Number:

Date of Initial License for Current Owners: 1/4/2007

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 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) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

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

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	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	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</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	<u>14,980</u>	<u>2,392</u>	<u>3,979</u>	<u>21,351</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,980</u>	<u>2,392</u>	<u>3,979</u>	<u>21,351</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 62.23%

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?

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 1/4/2007

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

YES

☒Date 1/4/2007

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

94

and days of care provided

1,484Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

* 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	135,048	10,216		145,264		145,264	3,887	149,151		1
2	Food Purchase		112,355		112,355		112,355	(3,520)	108,835		2
3	Housekeeping	80,469	16,712		97,181		97,181	30	97,211		3
4	Laundry	42,534	14,671		57,205		57,205	5	57,210		4
5	Heat and Other Utilities			79,730	79,730		79,730	307	80,037		5
6	Maintenance	34,155	13,056	18,683	65,894		65,894	2,610	68,504		6
7	Other (specify):* Home Off. Ben. All.							518	518		7
8	TOTAL General Services	292,206	167,010	98,413	557,629		557,629	3,837	561,466		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	916,899	73,851	2,836	993,586		993,586	(1,373)	992,213		10
10a	Therapy		206	324,293	324,499		324,499		324,499		10a
11	Activities	29,759	886	263	30,908		30,908	(8,757)	22,151		11
12	Social Services	30,514	26		30,540		30,540		30,540		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	977,172	74,969	339,392	1,391,533		1,391,533	(10,130)	1,381,403		16
	C. General Administration										
17	Administrative			236,800	236,800		236,800	(152,296)	84,504		17
18	Directors Fees										18
19	Professional Services			20,610	20,610		20,610	24,481	45,091		19
20	Dues, Fees, Subscriptions & Promotions			4,294	4,294		4,294	(17)	4,277		20
21	Clerical & General Office Expenses	31,295	9,299	17,578	58,172		58,172	46,077	104,249		21
22	Employee Benefits & Payroll Taxes			191,117	191,117		191,117	1,806	192,923		22
23	Inservice Training & Education							112	112		23
24	Travel and Seminar							7	7		24
25	Other Admin. Staff Transportation			8,206	8,206		8,206	5,366	13,572		25
26	Insurance-Prop.Liab.Malpractice			30,087	30,087		30,087	831	30,918		26
27	Other (specify):* Home Off. Ben. All.							10,379	10,379		27
28	TOTAL General Administration	31,295	9,299	508,692	549,286		549,286	(63,254)	486,032		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,300,673	251,278	946,497	2,498,448		2,498,448	(69,547)	2,428,901		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			136,729	136,729		136,729	(7,732)	128,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,253	33,253		33,253	20,867	54,120			32
33	Real Estate Taxes			38,766	38,766		38,766	550	39,316			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,500	6,500		6,500	613	7,113			35
36	Other (specify):*											36
37	TOTAL Ownership			215,248	215,248		215,248	14,298	229,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,069		66,069		66,069		66,069			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,109	247,109		247,109		247,109			42
43	Other (specify):* Non-allowable Costs	21,906	371	197,531	219,808		219,808	(219,808)				43
44	TOTAL Special Cost Centers	21,906	66,440	444,640	532,986		532,986	(219,808)	313,178			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,322,579	317,718	1,606,385	3,246,682		3,246,682	(275,057)	2,971,625			45

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

		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	(3,651)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,498)	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	(23,549)	30		9
10	Interest and Other Investment Income	(2,364)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(263)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,968)	43		18
19	Entertainment				19
20	Contributions	(300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,012)	43		24
25	Fund Raising, Advertising and Promotional	(23,365)	43		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 Page 5A	(19,632)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,602)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,455)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (14,455)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (275,057)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

STATE OF ILLINOIS
Swansea Rehabilitation & Health Care Center

Page 5A

ID# 0048611
Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,615)	43	1
2	X-Rays-Part A	(5,398)	43	2
3	Disallowed Special Events	(316)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(728)	21	4
5	Offset Transportation Revenue	(8,757)	11	5
6	Resident Flowers	(73)	43	6
7	Disallowed Chamber of Commerce Dues	(335)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(1,410)	10	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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,632)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swansea Rehabilitation & Health Care Center

0048611

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,887	0	0	0	0	0	0	0	0	0	3,887	1
2	Food Purchase	(3,651)	131	0	0	0	0	0	0	0	0	0	(3,520)	2
3	Housekeeping	0	30	0	0	0	0	0	0	0	0	0	30	3
4	Laundry	0	5	0	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	307	0	0	0	0	0	0	0	0	0	307	5
6	Maintenance	0	2,156	0	454	0	0	0	0	0	0	0	2,610	6
7	Other (specify):*	0	518	0	0	0	0	0	0	0	0	0	518	7
8	TOTAL General Services	(3,651)	7,034	0	454	0	0	0	0	0	0	0	3,837	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,410)	37	0	0	0	0	0	0	0	0	0	(1,373)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,757)	0	0	0	0	0	0	0	0	0	0	(8,757)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(10,167)	37	0	0	0	0	0	0	0	0	0	(10,130)	16
	C. General Administration													
17	Administrative	0	(152,296)	0	0	0	0	0	0	0	0	0	(152,296)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,996	0	3,485	0	0	0	0	0	0	0	24,481	19
20	Fees, Subscriptions & Promotions	(335)	0	299	19	0	0	0	0	0	0	0	(17)	20
21	Clerical & General Office Expenses	(728)	0	43,997	2,808	0	0	0	0	0	0	0	46,077	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,806	0	0	0	0	0	0	0	1,806	22
23	Inservice Training & Education	0	0	73	39	0	0	0	0	0	0	0	112	23
24	Travel and Seminar	0	0	7	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	0	5,041	325	0	0	0	0	0	0	0	5,366	25
26	Insurance-Prop.Liab.Malpractice	0	0	831	0	0	0	0	0	0	0	0	831	26
27	Other (specify):*	0	0	10,379	0	0	0	0	0	0	0	0	10,379	27
28	TOTAL General Administration	(1,063)	(131,300)	60,627	8,482	0	0	0	0	0	0	0	(63,254)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(14,881)	(124,229)	60,627	8,936	0	0	0	0	0	0	0	(69,547)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(23,549)	0	3,735	12,082	0	0	0	0	0	0	0	(7,732)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,364)	0	7,425	15,806	0	0	0	0	0	0	0	20,867	32
33	Real Estate Taxes	0	0	550	0	0	0	0	0	0	0	0	550	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	547	66	0	0	0	0	0	0	0	613	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,913)	0	12,257	27,954	0	0	0	0	0	0	0	14,298	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(219,808)	0	0	0	0	0	0	0	0	0	0	(219,808)	43
44	TOTAL Special Cost Centers	(219,808)	0	0	0	0	0	0	0	0	0	0	(219,808)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(260,602)	(124,229)	72,884	36,890	0	0	0	0	0	0	0	(275,057)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,887	\$ 3,887	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	131	131	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	30	30	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	5	5	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	307	307	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,156	2,156	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	518	518	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	37	37	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	236,800	Petersen Health Care, Inc.	100.00%	84,504	(152,296)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	20,996	20,996	12
13	V								13
14	Total			\$ 236,800			\$ 112,571	\$ * (124,229)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 299	\$ 299	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	43,997	43,997	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	73	73	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7	7	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	5,041	5,041	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	831	831	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,379	10,379	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,735	3,735	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,425	7,425	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	550	550	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%	547	547	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		\$			\$ 72,884	\$ * 72,884	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	454	454	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12 Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	3,485	3,485	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	19	19	26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	2,808	2,808	27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,806	1,806	28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	39	39	29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	325	325	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	12,082	12,082	34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	15,806	15,806	35
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	66	66	38
39	Total		\$			\$ 36,890	\$ * 36,890	39

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

Facility Name & ID Number

Swansea Rehabilitation & Health Care Center

0048611

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	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	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

Swansea Rehabilitation & Health Care Center

0048611

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

Swansea Rehabilitation & Health Care Center

0048611

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Cent # 0048611 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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											1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611

Report Period Beginning:

1/1/2012Ending: 2/31/2012

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

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

	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	1,569,393	74	\$ 285,707	\$ 284,214	21,351	\$ 3,887	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	21,351	131	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	21,351	30	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	21,351	5	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	21,351	307	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	21,351	2,156	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	21,351	518	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	21,351	37	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	21,351	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	21,351	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	21,351	84,504	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	21,351	20,996	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	21,351	299	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	21,351	43,997	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	21,351	73	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	21,351	7	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	21,351	5,041	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	21,351	831	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	21,351	10,379	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	21,351	3,735	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	21,351	7,425	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	21,351	550	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	21,351	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	21,351	547	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 185,455	25

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611

Report Period Beginning:

1/1/2012Ending: 2/31/2012

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

Petersen Health Care II, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	336,407	13	\$	\$	21,351	\$	1
2	2	Food	Resident Days	336,407	13			21,351		2
3	3	Housekeeping	Resident Days	336,407	13			21,351		3
4	4	Laundry	Resident Days	336,407	13			21,351		4
5	5	Utilities	Resident Days	336,407	13			21,351		5
6	6	Maintenance	Resident Days	336,407	13	7,156		21,351	454	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,407	13			21,351		7
8	10	Nursing and Medical Records	Resident Days	336,407	13			21,351		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,407	13			21,351		9
10	17	Administrative	Resident Days	336,407	13			21,351		10
11	19	Professional Services	Resident Days	336,407	13	54,918		21,351	3,485	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,407	13	300		21,351	19	12
13	21	Clerical and General Office	Resident Days	336,407	13	44,246		21,351	2,808	13
14	22	Employee Benefits & Payroll	Resident Days	336,407	13	28,459		21,351	1,806	14
15	23	Inservice Training & Education	Resident Days	336,407	13	617		21,351	39	15
16	24	Travel and Seminar	Resident Days	336,407	13			21,351		16
17	25	Other Admin. Staff Transport.	Resident Days	336,407	13	5,121		21,351	325	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,407	13			21,351		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,407	13			21,351		19
20	30	Depreciation	Resident Days	336,407	13	190,366		21,351	12,082	20
21	32	Interest	Resident Days	336,407	13	249,037		21,351	15,806	21
22	33	Real Estate Taxes	Resident Days	336,407	13			21,351		22
23	34	Rent-Facility and Grounds	Resident Days	336,407	13			21,351		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,407	13	1,038		21,351	66	24
25	TOTALS					\$ 581,258	\$		\$ 36,890	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	1ST Merit		X	Mortgage	Varies	02/01/12	\$ 749,900	\$ 733,052	01/31/17	Varies	\$ 33,253	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6												6		
7												7		
8												8		
9	TOTAL Facility Related						\$ 749,900	\$ 733,052			\$ 33,253	9		
	B. Non-Facility Related*													
10												10		
11								Interest Income Offset			(2,364)	11		
12								Home Office Allocation-PHC			7,425	12		
13								Home Office Allocation-PHC II			15,806	13		
14	TOTAL Non-Facility Related						\$	\$			\$ 20,867	14		
15	TOTALS (line 9+line14)						\$ 749,900	\$ 733,052			\$ 54,120	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

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.		\$	40,680	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.)		2011		\$	39,138	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,542)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	40,308	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.					550	
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.				\$	39,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	38,457	8
2008	39,865	9
2009	40,124	10
2010	39,473	11
2011	39,138	12

Accrual based on prior year tax bill.

	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

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
Swansea Rehabilitation & Health Care Center

COUNTY
St. Clair

FACILITY IDPH LICENSE NUMBER
0048611

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 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>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	08-16.0-409-014	Long-Term Care Facility	\$ 39,137.58	\$ 39,137.58
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 39,137.58	\$ 39,137.58

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 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:	30,000	B. General Construction Type:	Exterior	Brick	Frame	Steel	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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	100,800	2006	\$ 70,000	1
2					2
3	TOTALS	100,800		\$ 70,000	3

Facility Name & ID Number Swansea Rehabilitation & Health Care Center

0048611

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94		2006	1975	\$ 1,735,000	\$	30	\$ 57,833	\$ 57,833	\$ 375,915	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalk		2006		500		10	50	50	325	9
10	Landscaping		2007		1,685		15	112	112	448	10
11	Carpeting		2007		1,637		10	164	164	902	11
12	Awning		2007		815		10	82	82	451	12
13	Blinds		2007		1,883		10	188	188	1,034	13
14	Signage		2007		2,770		10	277	277	1,524	14
15	Roof Top Air Conditioners		2007		16,613		10	1,661	1,661	9,136	15
16	Landscaping		2008		3,385		15	226	226	1,017	16
17	Water Heater		2008		8,724		5	1,744	1,744	7,848	17
18	Cable Equipment Installation		2009		7,264		7	1,038	1,038	3,633	18
19	Water Heater		2010		7,490		10	750	750	1,875	19
20	Dining Room Floor		2010		8,638		15	1,152	1,152	2,880	20
21	Water Heater		2011		3,500		7	500	500	750	21
22	Water Line Repair		2011		4,822		7	688	688	1,032	22
23	Garage		2011		2,770		15	184	184	276	23
24	Smoke Detection System		2011		7,947		10	1,588	1,588	1,985	24
25	Water Heater		2012		3,637		7	260	260	260	25
26	Sprinkler System		2012		119,898		25	2,398	2,398	2,398	26
27											27
28											28
29											29
30	Land Improvements Booked					1,038			(1,038)		30
31	Building Booked					69,400			(69,400)		31
32	Building Improvement Booked					12,482			(12,482)		32
33											33
34	2012-Home Office Allocation-Land Improvements				932			60	60		34
35	2012-Home Office Allocation-Building Improvements				9,986			239	239		35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,949,896	\$ 82,920		\$ 71,194	\$ (11,726)	\$ 413,689	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$389,761	\$54,225	\$38,976	\$ (15,249)	5-10 yrs.	\$247,425	71
72	Current Year Purchases	8,209	801	410	(391)	10 yrs.	410	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			15,518	15,518			74
75	TOTALS	\$397,970	\$55,026	\$54,904	\$ (122)		\$247,835	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	2007 Ford E-150	2007	\$28,977	\$2,415	\$2,899	\$	5	\$28,977	76
77										77
78										78
79										79
80	TOTALS			\$28,977	\$2,415	\$2,899	\$		\$28,977	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,446,84381
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$140,36182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$128,99783**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(11,848)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$690,50185

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	N/A				87
88					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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 7,113 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

Fiscal Year Ending Annual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

* 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.

Swansea Rehabilitation & Health Care Center
0048611

Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

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

Medical Equipment	\$	5,768
Dishwasher		732
Laundry Equipment		-
Copier		-
Home Office Allocation		613
		<u>7,113</u>
		<u><u>7,113</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9,373	\$ 140,601	\$	9,373	\$ 140,601	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,006	30,094		2,006	30,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,233	153,488	206	10,233	153,694	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				66,069		66,069	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			7	110		7	110	13
14	TOTAL			\$	21,619	\$ 324,293	\$ 66,275	21,619	\$ 390,568	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 f (1,191,148)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 750	\$ 750	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 370,000)	1,102,144	1,102,144	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,830	29,830	6
7	Other Prepaid Expenses	9,014	9,014	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	5,628	5,628	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,147,366	\$ 1,147,366	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,570	70,000	13
14	Buildings, at Historical Cost	1,735,000	1,744,986	14
15	Leasehold Improvements, at Historical Cost	226,144	204,910	15
16	Equipment, at Historical Cost	430,372	426,947	16
17	Accumulated Depreciation (book methods)	(879,127)	(690,501)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): A/R Prior Owner	5,286	5,286	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,593,245	\$ 1,761,628	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,740,611	\$ 2,908,994	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,073,360	\$ 3,073,360	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,721	85,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,626	18,626	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,308	40,308	32
33	Accrued Interest Payable	2,574	2,574	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	37,227	37,227	36
37	Accrued Management Fees	108,197	108,197	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,366,013	\$ 3,366,013	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	733,052	733,052	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P Due To Due From	1,077	1,077	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 734,129	\$ 734,129	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,100,142	\$ 4,100,142	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,359,531)	\$ (1,191,148)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,740,611	\$ 2,908,994	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,450,573)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,450,576)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	91,045	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)	\$ 91,045	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)	\$ (1,359,531)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611Report Period Beginning: 1/1/2012Ending: 12/31/2012

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	\$ 2,932,057	1
2	Discounts and Allowances for all Levels	(294,274)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,637,783	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	544,001	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 544,001	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	3,651	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	130,334	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,977	20
21	Other Medical Services	2,722	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 142,684	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,364	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,138	28
28a	Transportation Revenue	8,757	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,895	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,337,727	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	557,629	31
32	Health Care	1,391,533	32
33	General Administration	549,286	33
	B. Capital Expense		
34	Ownership	215,248	34
	C. Ancillary Expense		
35	Special Cost Centers	285,877	35
36	Provider Participation Fee	247,109	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,246,682	40
41	Income before Income Taxes (line 30 minus line 40)**	91,045	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 91,045	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,072,512	44
45	Private Pay - Net Inpatient Revenue	307,095	45
46	Medicare - Net Inpatient Revenue	293,489	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(28,716)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(6,597)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,637,783	49

* 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.

*** 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	1,920	1,920	\$ 61,584	\$ 32.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,973	3,111	66,736	21.45	3
4	Licensed Practical Nurses	15,116	15,647	307,650	19.66	4
5	CNAs & Orderlies	42,325	43,476	452,620	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,638	1,729	20,860	12.06	9
10	Activity Assistants	514	515	5,721	11.11	10
11	Social Service Workers	2,080	2,080	30,514	14.67	11
12	Dietician					12
13	Food Service Supervisor	2,167	2,231	32,710	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,852	10,384	102,338	9.86	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	34,155	16.42	17
18	Housekeepers	8,602	8,832	80,469	9.11	18
19	Laundry	5,007	5,064	42,534	8.40	19
20	Administrator	2,080	2,080	84,504	40.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	31,295	15.05	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	2,771	2,929	53,393	18.23	33
34	TOTAL (lines 1 - 33)	101,205	104,158	\$ 1,407,083 *	\$ 13.51	34

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	4,740	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)		\$ 16,740		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

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

** See instructions.

Swansea Rehabilitation & Health Care Center
0048611
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,232	1,316	28,309	21.51
Transportation	318	318	3,178	9.99
Marketing	1,221	1,295	21,906	16.92
TOTAL	2,771	2,929	53,393	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jifi Jacob	Administrator	0	\$ 84,504
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,504
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 236,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 236,800
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 1,460
Charter Communications	Computer Services		1,203
Honkamp, Krueger & Co.	Accounting Services		1,904
Knapp, Ohl & Green	Legal Services		500
Brown & James	Legal Services		13,895
Sorling Northrup	Legal Services		1,648
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 20,610
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 36,600
Unemployment Compensation Insurance			35,012
FICA Taxes			99,329
Employee Health Insurance			17,226
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			2,950
Home Office Allocation			1,806
TOTAL (agree to Schedule V, line 22, col.8)			\$ 192,923
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	131		1,311
Miscellaneous Licenses & Permits			658
Miscellaneous Dues & Subscriptions			335
Home Office Allocation			318
Less: Public Relations Expense			(335)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,277
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			7
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 7

*** Attach copy of IMRF notifications**

****See instructions.**

Swansea Rehabilitation & Health Care Center
0048611
Period Beginning 1/1/2012
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		20,610
Home Office Allocation		
Sorling Northrup	Legal	67
Ginoli & Company	Accountants	1,492
Miscellaneous	Computer Services	84
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	3244
Access 2 Go	Computer Services	136
Stratus Networks	Computer Services	134
Kemper Technology	Computer Services	221
CCH	Computer Services	12
Medifax	Computer Services	26
Vision Share/Ability Network	Computer Services	247
Barracuda	Computer Services	9
CIAN	Computer Services	67
Comcast	Computer Services	21
Postini	Computer Services	210
Optimizer Systems	Other Prof Fees	33
Marotta Gund Budd & Dzera	Other Prof Fees	15023
David Budde	Other Prof Fees	13
Courtney Bourban	Other Prof Fees	185
All Scripts	Other Prof Fees	806
Heritage Enterprises	Other Prof Fees	13
Miscellaneous Vendors	Other Prof Fees	4
Katten Muchin Rosenman	Legal	822
U.S. Bank	Accountants	1,048
Medifax-EDI	Computer Services	81

Polaris Group	Other Prof Fees	326
Healthlink	Other Prof Fees	155

Total (agree to Schedule V, line 19, column 8)	<u>45,091</u>
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Swansea Rehabilitation & Health Care Center
0048611

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility	Invoice	Allocation	
Vendor/Payee	Total	%	Total
Brown & James	1,773.27	100%	1,773
Brown & James	4,626.58	100%	4,627
Brown & James	337.50	100%	338
Brown & James	692.85	100%	693
Brown & James	715.71	100%	716
Brown & James	297.49	100%	297
Knapp, Ohl & Green Howard Collection	500.00	100%	500
Sorling Northrup	105.00	100%	105
Brown & James	4,850.99	100%	4,851
Brown & James	610.75	100%	611
Brown & James	1,533.00	100%	1,533
Home Office Allocation			
Sorling Northrup	5,053.00	1.32%	67
Katten Muchin Rosenman	12,947.00	6.35%	822
			-
			-
			-
Total Legal Fees			16,932

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
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?
If YES, give association name and amount.

No
- (3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 14,281 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

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

No
N/A
- (9) Are you presently operating under a sublease agreement?

YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 247,109
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

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

Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 3,651
- (16) Travel and Transportation

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

No

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

Yes
8,757

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

No
\$
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

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

Yes