

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	LP Mortgage HUD Loan		X	Facility Purchase Financing	\$33,276.00	11/1/12	\$ 8,377,500	\$ 7,695,535	11/1/42	0.0254	\$ 197,818	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	GE Healthcare Finance		X	Working Capital		06/24/14	5,750,000		10/27/19	Variable		6	
7												7	
8												8	
9	TOTAL Facility Related				\$33,276.00		\$ 14,127,500	\$ 7,695,535			\$ 197,818	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 14,127,500	\$ 7,695,535			\$ 197,818	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 38,937 Line # 36

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

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

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	Swann Special Care Center	COUNTY	Champaign
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CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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

Page 10A

A. Square Feet: 25,257

B. General Construction Type: Exterior Block & BrickFrame WoodNumber 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).

Swann School Education Program, operated onsite; cost removal adjustments & allocation to remove associated costs shown on SCH V and further explanation on Pg 11.2

Swann Developmental Day Training Program, operated onsite; cost removal adjustments & allocation to remove associated costs shown on SCH V and further explanation on Pg 11.2

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

Swann Special Care Center
Schedule X Supplemental Schedule
Item 14 - Allocation of non-long term care costs

(E) Swann Special Care Center operates Education and Developmental Day Training programs in dedicated spaces offsite from the skilled nursing facility. All costs specifically attributable to these programs in dedicated GL accounts, including wages/salaries, supplies, rent and occupancy costs, have been grouped in line 39 of Schedule V, "Ancillary Service Centers", and are removed via adjustment on Schedule VI, Line 3.

In addition, a portion of all other cost centers and expense items which provide benefits and support to the Education and Day Training programs are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

Costs incurred which benefit multiple operational programs are identified, segregated, and reported each year in conjunction with required cost report filings to the Illinois Purchased Care Review Board for the Educational program. The percentage of costs identified for each program from the most recent ILPCRB report are utilized to calculate the portion attributable to Day Training and Education which is removed in this Cost Report. A percentage of wages and salaries expense, identifiable to each specific program and position, is utilized to allocate Employee benefits and payroll taxes. Hours of operation of each program are utilized to allocate certain administrative, overhead, and support services, and other allocation bases are utilized for applicable shared costs.

The results of these allocations appear on Schedule VI, as adjustments to remove shared costs attributable to non-long term care services.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	87		1989	1978	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,855,735	4	
5	9			1993	N/A						5	
6	8			1996	N/A						6	
7	8			2000	N/A						7	
8	11			2004	N/A						8	
	Improvement Type**											
9	Drain Tile Installation			10/23/2013	11,896.63	1,189.66	10	1,190		3,172.43	9	
10	Security System for Front Do			3/5/2014	3,547.00	354.70	10	355		827.63	10	
11	Mop Room Renovation			4/14/2014	3,520.00	352.00	10	352		792.00	11	
12	Mop Room Renovation			4/15/2014	4,635.75	463.58	10	464		1,043.05	12	
13	TheraPure Tub			8/26/2014	12,038.12	1,203.81	10	1,204		2,206.99	13	
14	Whirlpool Room Flooring			8/27/2014	4,300.00	430.00	10	430		788.33	14	
15	Team 8 Shower Room Flooring			2/17/2015	7,600.00	760.00	10	760		1,013.33	15	
16	HVAC unit			6/1/2016	5,755.00	47.96	10	48		47.96	16	
17	MATERIALS FOR LEASEHOLD I			2/1/1995	7,858.06	-	3			7,858.06	17	
18	CONSTRUCT SHELIVING,BEDS,S			12/18/1996	2,964.00	-	3			2,964.00	18	
19	BALANCE-INSTALL ALARM SYS			6/29/2000	2,730.00	-	5			2,730.00	19	
20	INSTALL CLINICAL SINK.			7/18/2000	3,030.00	-	5			3,030.00	20	
21	REPLACE DOORS			1/2/2002	3,000.00	-	5			3,000.00	21	
22	SECURITY SYSTEM			2/21/2002	3,165.00	-	5			3,165.00	22	
23	INSTALL TWO SINKS			5/13/2002	3,561.00	-	5			3,561.00	23	
24	INSTALLED NEW PHONE SYS.S			10/15/2002	2,735.00	-	5			2,735.00	24	
25	FIRE DOORS			7/16/1990	2,751.00	-	10			2,751.00	25	
26	STORM WINDOW			6/17/1991	4,224.50	-	10			4,224.50	26	
27	FIRE DOORS			6/20/1991	3,675.00	-	10			3,675.00	27	
28	SPRINKLER/EXIT DEVICES OD			1/30/1992	3,162.00	-	10			3,162.00	28	
29	ROOFING			12/4/1992	3,900.00	-	10			3,900.00	29	
30	SPRINKLER SYSTEM			3/30/1993	14,460.00	-	10			14,460.00	30	
31	WALL COVERING			5/20/1993	3,190.36	-	10			3,190.36	31	
32	WALL PAPERING			6/28/1993	3,000.00	-	10			3,000.00	32	
33	CARPET AND RUBBER BASE			7/23/1993	2,848.00	-	10			2,848.00	33	
34	FIRE DOORS, CLOSETS, TILE			11/1/1993	5,225.00	-	10			5,225.00	34	
35	HOODS, FANS, ANSUL SYSTEM			3/14/1995	2,500.00	-	10			2,500.00	35	
36	WORK FOR EXHAUST FAN & HO			4/6/1995	3,995.00	-	10			3,995.00	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:

07/01/2015 Ending: 06/30/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 REPLACE WATER HEATER	6/15/1995	\$ 3,750.00	\$ -	10	\$	\$	\$ 3,750.00	37
38 WALK-IN COOLER	10/24/1995	3,333.55	-	10			3,333.55	38
39 REPLACE 2 ROOFTOP HVAC UN	12/7/1998	17,650.00	-	10			17,650.00	39
40 REMOVE/RPLCE HOT WATER HE	5/25/1999	3,000.00	-	10			3,000.00	40
41 REPLACE RELAY ON GENERATO	10/5/1999	2,782.29	-	10			2,782.29	41
42 INSTALL DOORS AT KENWOOD	7/18/2000	4,028.41	0.01	15	0		4,028.41	42
43 REPLACE GATE VALVE/INSTAL	9/8/2000	6,005.22	66.78	15	67		6,005.22	43
44 NEW FLOOR DRAINS IN SHOWE	1/24/2001	3,180.00	105.90	15	106		3,180.00	44
45 INSTALL SHOWER DRAINS	7/16/2001	10,500.00	525.00	20	525		7,875.00	45
46 INTERNET SET-UP-WIRING, C	2/21/2002	6,140.86	409.39	15	409		5,902.11	46
47 CARPET AND INSTALLATION	7/16/2002	2,954.00	-	10			2,954.00	47
48 INSTALL A/C ROOFTOP UNIT	8/26/2002	8,237.31	549.15	15	549		7,642.31	48
49 HEIGHT ADJ.SUPINE TUB	12/16/2002	8,469.14	-	10			8,469.14	49
50 CENTRAL HEAT/AIR ROOFTOP	1/22/2003	5,180.00	345.33	15	345		4,661.97	50
51 ELECTRIC WATER HEATER	3/17/2003	5,600.00	-	10			5,600.00	51
52 Rooftop unit installed; heat	7/31/2003	10,910.00	727.33	15	727		9,394.68	52
53 roofing project-Wing 1,2,4 (	6/8/2005	66,485.00	4,432.33	15	4,432		49,124.99	53
54 Re-tile shower room	4/27/2006	10,714.00	714.27	15	714		7,261.74	54
55 Deposit for duro last roof	7/13/2006	10,000.00	666.67	15	667		6,666.70	55
56 Duro last roof - payment #2	7/13/2006	4,383.92	292.26	15	292		2,922.60	56
57 100 amp sub panel	9/25/2006	2,649.59	176.64	15	177		1,722.24	57
58 Re-tile shower room #10	9/27/2006	11,642.00	776.13	15	776		7,567.27	58
59 Re-tile shower room #3	12/15/2006	11,642.00	776.13	15	776		7,437.91	59
60 Re-tile shower room #4	12/28/2006	11,642.00	776.13	15	776		7,373.24	60
61 Replace walls in dishwasher	12/5/2006	7,477.26	498.48	15	498		4,777.10	61
62 Re-tile shower room #s 5,6,7	3/15/2007	12,746.00	849.73	15	850		7,930.81	62
63 Re-tile team 6 bathroom	8/29/2007	7,560.92	504.06	15	504		4,452.53	63
64 Rpl motors on roof exhaust f	8/7/2007	2,667.17	266.72	10	267		2,378.25	64
65 Upgrade lighting system in e	8/21/2007	6,501.38	433.43	15	433		3,828.63	65
66 Wire breakroom & outlets for	12/4/2007	2,574.32	171.62	15	172		1,473.07	66
67 Replace 2 doors in laundry a	2/29/2008	4,187.00	279.13	15	279		2,326.08	67
68 Remodel conf room (cabinets,	7/10/2008	2,536.02	253.60	10	254		2,028.80	68
69 Addtnl outlets (4 ea.) in ro	12/4/2008	7,625.00	508.33	15	508		3,854.84	69
70 TOTAL (lines 4 thru 69)		\$ 3,012,021	\$ 76,181		\$ 76,181	\$	\$ 2,166,956	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:

07/01/2015 Ending: 06/30/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,012,021	\$ 76,181		\$ 76,181	\$	\$ 2,166,956	1
2	Compressor for a/c unit	9/11/2009	2,830.00	283.00	10	283		1,933.83	2
3	Induct air purifiers (8) and	12/14/2009	3,637.79	363.78	10	364		2,394.88	3
4	Outlets (24) in resident roo	10/9/2010	12,618.04	841.20	15	841		4,836.90	4
5	Outlets in rooms 3b/1b/5a/6a	12/16/2010	8,280.00	552.00	15	552		3,036.00	5
6	Outlets in rooms 7a/7b/13/14	1/24/2011	13,800.00	920.00	15	920		4,983.33	6
7	Compressor & blower wheel	6/28/2011	2,575.00	257.50	10	258		1,287.50	7
8	Sprinklers for ext eaves on	9/20/2011	4,275.00	427.50	10	428		2,030.63	8
9	Tile floor & walls of bathro	11/29/2011	19,853.80	1,323.59	15	1,324		6,066.45	9
10	Heat exchanger	12/12/2011	4,035.00	403.50	10	404		1,849.38	10
11	Heat exchanger	3/16/2012	6,570.00	657.00	10	657		2,792.25	11
12	Network drops (32) for Paige	12/13/2011	2,550.00	255.00	10	255		1,168.75	12
13	Renovate shower rooms #2/14/	4/23/2012	19,500.00	1,300.00	15	1,300		5,416.67	13
14	Flooring for shower room	10/18/2012	6,000.00	600.00	10	600		2,200.00	14
15	Weatherization project	7/1/2012	3,099.00	309.90	10	310		1,239.60	15
16	Exterior painting & waterpro	10/26/2012	9,752.00	650.13	15	650		2,383.81	16
17	Emergency generator	2/28/2013	63,610.00	4,240.67	15	4,241		14,135.57	17
18	IDPH Electrical Work(Project	5/1/2013	32,000.00	2,133.33	15	2,133		6,755.55	18
19	New Flooring Installed	5/1/2013	6,132.50	408.83	15	409		1,294.63	19
20	New Flooring Installed - 3rd	5/13/2013	6,000.00	400.00	15	400		1,266.67	20
21	IDPH Electrical Work(Project	6/25/2013	17,855.00	1,190.33	15	1,190		3,570.99	21
22	RESURFACE PARKING LOT	11/1/1993	19,115.00	-	10			19,115.00	22
23	REPLACE UNDERGROUND FUEL	11/11/1998	9,223.00	461.15	20	461		8,147.03	23
24	RE-SEAL AND RE-STRIPE PAR	7/1/2002	2,810.00	-	10			2,810.00	24
25	Install draining system in c	2/2/2004	9,267.57	-	7			9,267.57	25
26	Parking lot/dumpster pad rep	10/20/2006	8,073.00	807.30	10	807		7,803.90	26
27	Fence/dumpster enclosure	12/16/2006	2,750.00	275.00	10	275		2,612.50	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,308,232	\$ 95,242		\$ 95,242	\$	\$ 2,287,356	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	\$148,921	\$26,970	\$26,970	\$	3-10	\$98,397	71
72	Current Year Purchases	31,488	1,874	1,874		5-7	1,874	72
73	Fully Depreciated Assets	812,615	3,584	3,584		3-10	812,615	73
74	Depr Exp (Net Allowable) - Rel Pty Alloc Sch VIII		4,085	4,085				74
75	TOTALS	\$993,024	\$36,513	\$36,513	\$		\$912,886	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	4,839,256
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	131,755
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	131,755
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,200,242

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	Transportation Equip Not Allowed	\$186,242	\$11,268	\$179,032	86
87	Assets below IL Capital Threshold	593,991	31,180	490,677	87
88	Assets Disallowed by DHS Cap Review	1,156,556	30,906	909,090	88
89					89
90					90
91	TOTALS	\$1,936,789	\$73,354	\$1,578,799	91

G. Construction-in-Progress			
	Description	Cost	
92	Facility Addition	\$371,583	92
93	Shower room plumbing	1,105	93
94	Tank removal	7,750	94
95		\$380,438	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 - Facility Leased from 100% Commonly-owned Related Party (See Sch VII)
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	Corp Group Office Allocation		N/A	12/1/2011	9,051	10	10	5
6								6
7	TOTAL				\$ 9,051			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: \$ 15,611
- Description: Copy/Scanners: \$5,129; Postage Meter: \$2,072; Short Term Medical Equip: \$7,891; Corp Alloc: \$519
- (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 12/1/2011

Ending 12/1/2021

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2017</u>	\$ <u>Corp Alloc Amt</u>
13.	<u>6/30/2018</u>	\$ <u>Corp Alloc Amt</u>
14.	<u>6/30/2019</u>	\$ <u>Corp Alloc Amt</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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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	\$	1,338	\$ 64,765	\$ 2,848	1,338	\$ 67,613	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,023	73,297		1,023	73,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		125	6,234	444	125	6,678	4
5	Physician Care	39.3	visits			9,600			9,600	5
6	Dental Care	39.3	visits		161	6,420		161	6,420	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		96	6,256		96	6,256	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs		43	4,300		43	4,300	10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>				59	1,778	556	59	2,333	12
13	Other (specify): <u>Note: Line 5 Physician Care is flat fee Neurologist evals</u>									13
14	TOTAL			\$	2,845	\$ 172,649	\$ 3,848	2,845	\$ 176,497	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	\$ 500	\$ 1,100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,068)	1,774,231	1,774,231	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(24,762)	6,104	6
7	Other Prepaid Expenses	22,251	22,251	7
8	Accounts Receivable (owners or related parties)	4,859,234	4,859,234	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,631,454	\$ 6,662,920	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		4,616,463	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,621,582	16
17	Accumulated Depreciation (book methods)		(4,779,040)	17
18	Deferred Charges		194,656	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		224,088	21
22	Other Long-Term Assets (spe CIP		380,438	22
23	Other(specify): Goodwill	531,191	531,191	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 531,191	\$ 3,327,378	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,162,645	\$ 9,990,298	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,982	\$ 243,982	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		206,232	29
30	Accrued Salaries Payable	444,987	444,987	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,591	27,591	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		16,289	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany/Due to Lessor		394,839	36
37	Rounding	(2)	(2)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 716,558	\$ 1,333,918	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,489,303	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,489,303	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 716,558	\$ 8,823,221	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,446,087	\$ 1,167,077	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,162,645	\$ 9,990,298	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,652,438	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,652,438	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	793,649	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)	\$ 793,649	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)	\$ 6,446,087	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,653,127	1
2	Discounts and Allowances for all Levels	6	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,653,133	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	792,597	9
10	Other Government Grants	54,123	10
11	CNA Training Reimbursements	9,832	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)	\$ 856,552	23
	D. Non-Operating Revenue		
24	Contributions	26,032	24
25	Interest and Other Investment Income***	128	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,160	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	(692)	27
28	Day Training	1,874,045	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,873,353	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,409,198	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,065,822	31
32	Health Care	3,690,862	32
33	General Administration	2,074,021	33
	B. Capital Expense		
34	Ownership	623,068	34
	C. Ancillary Expense		
35	Special Cost Centers	1,740,052	35
36	Provider Participation Fee	421,724	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,615,549	40
41	Income before Income Taxes (line 30 minus line 40)**	793,649	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 793,649	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,542,916	44
45	Private Pay - Net Inpatient Revenue	97,360	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	12,857	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,653,133	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,935	2,125	\$ 104,602	\$ 49.22	1
2	Assistant Director of Nursing	1,843	2,036	75,357	37.01	2
3	Registered Nurses	35,224	38,410	1,110,097	28.90	3
4	Licensed Practical Nurses	8,994	9,916	197,421	19.91	4
5	CNAs & Orderlies	91,787	99,882	1,317,251	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,976	5,571	68,131	12.23	8
9	Activity Director	1,777	2,018	42,394	21.01	9
10	Activity Assistants	15,112	16,388	160,462	9.79	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,841	2,083	52,749	25.32	13
14	Head Cook	12,914	14,297	193,562	13.54	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,806	4,264	75,844	17.79	17
18	Housekeepers					18
19	Laundry	2,030	2,175	20,314	9.34	19
20	Administrator	1,835	2,086	103,834	49.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,118	6,743	115,625	17.15	24
25	Vocational Instruction	71,338	78,701	1,172,860	14.90	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)	4,012	4,405	68,226	15.49	30
31	Medical Records					31
32	Other Health Care(specify)	1,962	2,112	28,152	13.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,504	293,212	\$ 4,906,881 *	\$ 16.73	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	318	\$ 13,297	3.1	35
36	Medical Director	N/A	45,600	3.9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)	318	\$ 58,897		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

Page 21

Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kym Halberstadt	Administrator	0	\$ 103,834
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,834

B. Administrative - Other

Description	Amount
	\$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehab (dba Ex Living Ctrs)	Management Services	\$ 552,216
ADP / Paycor	Payroll Processing	19,330
Various	Accounting/audit services	16,348
Various (see 21.1 for detail)	Legal services	14,964
VCPI, BrekGroup, PhonesPlus	Information Tech Services	3,013
Various	Admin svcs, document svcs	1,827
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 607,698

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 89,595
Unemployment Compensation Insurance	29,252
FICA Taxes	257,512
Employee Health Insurance	477,627
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	6,281
Group Allocation - Pg 8	31,383
Less Pg5A Adj for Unallowable DT/EDU	(199,359)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 692,291

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None.		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	11,255
Health Care Worker Background Check (Indicate # of checks performed 25)	890
Public Rel/Mkting/Fundraising	20,000
Bank Fees	44,175
Other Dues, Fees, Subs (net)	5,877
Group Allocation - Pg8	1,265
Less Pg5A Adj for Unallowable DT/EDU	(24,666)
Less: Public Relations Expense	(20,000)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 38,796

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
N/A	
In-State Travel	
See Page 21.2 for Detail	2,823
SCH VI Adj - Unallowable items	(1,474)
Corporate/Group Travel Alloc - G&A	27,567
Seminar Expense	
SCH VI Adj - DT/EDU Alloc	(399)
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 28,517

* Attach copy of IMRF notifications

**See instructions.

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
7/29/2015	Mary Ann Royse Law Office	157.50
8/19/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	53.33
8/26/2015	Duane Morris LLP	34.00
9/22/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	796.49
9/22/2015	Mary Ann Royse Law Office	262.50
12/14/2015	Duane Morris LLP	22.67
2/5/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	160.00
2/5/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	200.00
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	195.33
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	387.17
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	155.42
6/6/2016	Mary Ann Royse Law Office	96.25
6/20/2016	Mary Ann Royse Law Office	35.00
6/20/2016	Mary Ann Royse Law Office	218.75
6/20/2016	Mary Ann Royse Law Office	122.50
7/14/2015	Stites&Harbison PLLC	22.00
10/19/2015	Stites&Harbison PLLC	5.46
10/19/2015	Stites&Harbison PLLC	8.19
5/17/2016	Stites&Harbison PLLC	62.34
7/31/2015	In-House Counsel Legal Fees	915.03
8/31/2015	In-House Counsel Legal Fees	1,008.22
9/30/2015	In-House Counsel Legal Fees	883.86
10/31/2015	In-House Counsel Legal Fees	886.31
11/30/2015	In-House Counsel Legal Fees	936.32
12/31/2015	In-House Counsel Legal Fees	840.06
1/31/2016	In-House Counsel Legal Fees	(89.87)
1/31/2016	In-House Counsel Legal Fees	1,159.63
2/29/2016	In-House Counsel Legal Fees	1,103.93
3/31/2016	In-House Counsel Legal Fees	1,151.66
4/30/2016	In-House Counsel Legal Fees	1,002.49
5/31/2016	In-House Counsel Legal Fees	1,094.14
6/30/2016	In-House Counsel Legal Fees	1,076.98
		<u><u>\$14,963.66</u></u>

See Schedule VI for adjustment for unallowable portion.

Swann Special Care Center

Schedule XIX Supplemental Schedule

Travel & Seminar In-State detail:

DESCRIPTION	Amount	SCH V LINE.COL
-------------	--------	----------------

1 In-State Travel Detail

Abdul Rebhl, Restorative Assistant, care-related in-state travel	52	24.3
Ferdinand Mendoza, Education, in-state travel	432	24.3
Gale Kirkpatrick, Maintenance, in-state travel	333 A	24.3
John Lawrence, Education, special education conference	540 A	24.3
Kym Halberstadt, Exec Director, care-related in-state travel	524	24.3
Mary J. Ward, DON, care-related in-state travel	58	24.3
Monette Calundan, Activities Assistant, care-related in-state travel	5	24.3
Patti Talkington, C.N.A., care-related in-state travel	94	24.3
Rhea Maligaya, Day Training, in-state travel	53	24.3
Roseller Dimla, Health Unit Coord., resident appointments	132	24.3
Corporate/Group travel allocation of operations personnel	418 A	24.3
In-state business meals	183 A	24.3
	<u>2,823</u>	

1 Out-of-State Travel (All to Home Office or Care-related training) Detail

n/a	-	24.3
	<u>-</u>	

Line 24 Column 4 Total:	<u>2,823</u>	(0)
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Line 24 Column 7 Adjustment - Corporate/Home Office Allocated Costs	27,567	
---	--------	--

Unallowable Amounts above removed through SCH 5 Adjustments:

A Non-care related amounts noted above:	(1,474)	
Allocation for non-care-related Education and Day Training	(399)	
(See Pg 11.2 & 5A)		

Line 24 Column 8 Total:	<u>28,517</u>	(0)
-------------------------	---------------	-----

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. ILHCA, \$4,243 net after Schedule VI 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 147,306 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 421,724
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 54,123
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? See Pg 21.1
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: Crowe Horwath
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees