

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0048611

Facility Name: Swansea Rehab & Hlth Cr Ctr

Address: 1405 North Second St 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 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (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 Rehab & Hlth Cr Ctr

0048611 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

1	2	3	4		
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period		
1	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	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	22,281	1,906	1,557	25,744	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,281	1,906	1,557	25,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.03%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES X NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

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 X Date NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 94 and days of care provided 1,192

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL X CASH* CASH*

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

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

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

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr # 0048611 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	131,221	11,346		142,567		142,567	5,288	147,855			1
2	Food Purchase		148,131		148,131		148,131	(2,549)	145,582			2
3	Housekeeping	122,477	35,504		157,981		157,981	92	158,073			3
4	Laundry	43,600	13,756	148	57,504		57,504		57,504			4
5	Heat and Other Utilities			88,576	88,576		88,576	308	88,884			5
6	Maintenance	31,018	7,805	21,142	59,965		59,965		59,965			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	328,316	216,542	109,866	654,724		654,724	3,139	657,863			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,063,673	130,134	6,462	1,200,269		1,200,269	(1,056)	1,199,213			10
10a	Therapy			261,099	261,099		261,099		261,099			10a
11	Activities	46,538	157	713	47,408		47,408	(2,246)	45,162			11
12	Social Services	31,492	738		32,230		32,230		32,230			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,141,703	131,029	280,274	1,553,006		1,553,006	(3,302)	1,549,704			16
	C. General Administration											
17	Administrative			319,500	319,500		319,500	(230,500)	89,000			17
18	Directors Fees											18
19	Professional Services			11,795	11,795		11,795	37,311	49,106			19
20	Dues, Fees, Subscriptions & Promotions			7,690	7,690		7,690	1,098	8,788			20
21	Clerical & General Office Expenses	26,488	6,530	16,428	49,446		49,446	61,494	110,940			21
22	Employee Benefits & Payroll Taxes			204,862	204,862		204,862	37,358	242,220			22
23	Inservice Training & Education							118	118			23
24	Travel and Seminar			95	95		95	57	152			24
25	Other Admin. Staff Transportation			5,098	5,098		5,098	4,850	9,948			25
26	Insurance-Prop.Liab.Malpractice			29,562	29,562		29,562	683	30,245			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	26,488	6,530	595,030	628,048		628,048	(87,531)	540,517			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,496,507	354,101	985,170	2,835,778		2,835,778	(87,694)	2,748,084			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			90,515	90,515		90,515	22,150	112,665			30
31	Amortization of Pre-Op. & Org.							26,762	26,762			31
32	Interest			29,714	29,714		29,714	36,646	66,360			32
33	Real Estate Taxes			45,174	45,174		45,174	314	45,488			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,657	29,657		29,657	1,109	30,766			35
36	Other (specify):*											36
37	TOTAL Ownership			195,060	195,060		195,060	86,981	282,041			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,230		49,230		49,230		49,230			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,173	198,173		198,173		198,173			42
43	Other (specify):*		22	312,642	312,664		312,664	(312,664)				43
44	TOTAL Special Cost Centers		49,252	510,815	560,067		560,067	(312,664)	247,403			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,496,507	403,353	1,691,045	3,590,905		3,590,905	(313,377)	3,277,528			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,645)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,197)	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	7,322	30		9
10	Interest and Other Investment Income	(985)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(180)	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	(39,582)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(253,700)	43		24
25	Fund Raising, Advertising and Promotional	(1,541)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(8,976)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (312,584)		\$	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)	(793)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (793)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (313,377)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,639)	43	1
2	X-Rays-Part A	(2,100)	43	2
3	Disallowed Special Events	(187)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(153)	21	4
5	Offset Transporation Revenue	(2,246)	11	5
6	Resident Flowers	(438)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(1,213)	10	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
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	(8,976)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr# 0048611

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	5,288	0	0	0	0	0	0	0	0	0	5,288	1
2	Food Purchase	(2,645)	96	0	0	0	0	0	0	0	0	0	(2,549)	2
3	Housekeeping	0	92	0	0	0	0	0	0	0	0	0	92	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	308	0	0	0	0	0	0	0	0	0	308	5
6	Maintenance	0	2,887	0	0	0	0	0	0	0	0	0	2,887	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,645)	8,671	0	0	0	0	0	0	0	0	0	6,026	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	(1,213)	157	0	0	0	0	0	0	0	0	0	(1,056)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,246)	0	0	0	0	0	0	0	0	0	0	(2,246)	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	(3,459)	157	0	0	0	0	0	0	0	0	0	(3,302)	16
	C. General Administration													
17	Administrative	0	(230,500)	0	0	0	0	0	0	0	0	0	(230,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,467	0	23,844	0	0	0	0	0	0	0	37,311	19
20	Fees, Subscriptions & Promotions	0	0	563	535	0	0	0	0	0	0	0	1,098	20
21	Clerical & General Office Expenses	(153)	0	61,647	0	0	0	0	0	0	0	0	61,494	21
22	Employee Benefits & Payroll Taxes	0	0	34,471	0	0	0	0	0	0	0	0	34,471	22
23	Inservice Training & Education	0	0	118	0	0	0	0	0	0	0	0	118	23
24	Travel and Seminar	0	0	57	0	0	0	0	0	0	0	0	57	24
25	Other Admin. Staff Transportation	0	0	4,850	0	0	0	0	0	0	0	0	4,850	25
26	Insurance-Prop.Liab.Malpractice	0	0	683	0	0	0	0	0	0	0	0	683	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(153)	(217,033)	102,389	24,379	0	0	0	0	0	0	0	(90,418)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,257)	(208,205)	102,389	24,379	0	0	0	0	0	0	0	(87,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr # 0048611 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	7,322	0	13,642	1,186	0	0	0	0	0	0	0	22,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	26,762	0	0	0	0	0	0	0	26,762	31
32	Interest	(985)	0	401	37,230	0	0	0	0	0	0	0	36,646	32
33	Real Estate Taxes	0	0	314	0	0	0	0	0	0	0	0	314	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,109	0	0	0	0	0	0	0	0	1,109	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,337	0	15,466	65,178	0	0	0	0	0	0	0	86,981	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):*	(312,664)	0	0	0	0	0	0	0	0	0	0	(312,664)	43
44	TOTAL Special Cost Centers	(312,664)	0	0	0	0	0	0	0	0	0	0	(312,664)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(312,584)	(208,205)	117,855	89,557	0	0	0	0	0	0	0	(313,377)	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 Management, Inc.	100.00%	\$ 5,288	\$ 5,288	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	96	96	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	92	92	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	308	308	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,887	2,887	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	157	157	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	319,500	Petersen Health Care Management, Inc.	100.00%	89,000	(230,500)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,467	13,467	12
13	V								13
14	Total			\$ 319,500			\$ 111,295	\$ * (208,205)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 563	\$ 563	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	61,647	61,647	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	34,471	34,471	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	118	118	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	57	57	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,850	4,850	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	683	683	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	13,642	13,642	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	401	401	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	314	314	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,109	1,109	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			\$			\$ 117,855	\$ * 117,855	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Care II, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Care II, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, LLC	100.00%	23,844	23,844	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%	535	535	26
27	V	21	Clerical and General Office		Petersen Health Care II, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Care II, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Care II, LLC	100.00%	1,186	1,186	33
34	V	31	Amortization		Petersen Health Care II, LLC	100.00%	26,762	26,762	34
35	V	32	Interest		Petersen Health Care II, LLC	100.00%	37,230	37,230	35
36	V	33	Real Estate Taxes		Petersen Health Care II, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	0		38
39	Total			\$			\$ 89,557	\$ * 89,557	39

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

Facility Name & ID Number

Swansea Rehab & Hlth Cr Ctr

0048611

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Swansea Rehab & Hlth Cr Ctr

0048611

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Swansea Rehab & Hlth Cr Ctr

0048611

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr # 0048611 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr# 0048611

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	25,744	\$ 5,288	1
2	2	Food	Resident Days	75	5,673	0	25,744	96	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	25,744	92	3
4	5	Utilities	Resident Days	75	18,209	0	25,744	308	4
5	6	Maintenance	Resident Days	75	170,632	137,057	25,744	2,887	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	25,744	0	6
7	9	Medical Director	Resident Days	75	0	0	25,744	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	25,744	157	8
9	10A	Therapy	Resident Days	75	0	0	25,744	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	25,744	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	25,744	89,000	11
12	19	Professional Services	Resident Days	75	795,918	0	25,744	13,467	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	25,744	563	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	25,744	61,647	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	25,744	34,471	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	25,744	118	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	25,744	57	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	25,744	4,850	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	25,744	683	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	25,744	0	20
21	30	Depreciation	Resident Days	75	806,271	0	25,744	13,642	21
22	32	Interest	Resident Days	75	23,686	0	25,744	401	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	25,744	314	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	25,744	1,109	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 229,150	25

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr# 0048611

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care II, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	158,706	5	\$	\$	25,744	\$	1
2	2	Food	Resident Days	158,706	5			25,744		2
3	3	Housekeeping	Resident Days	158,706	5			25,744		3
4	4	Laundry	Resident Days	158,706	5			25,744		4
5	5	Utilities	Resident Days	158,706	5			25,744		5
6	6	Maintenance	Resident Days	158,706	5			25,744		6
7	7	Mgmt. Allocation of Benefits	Resident Days	158,706	5			25,744		7
8	10	Nursing and Medical Records	Resident Days	158,706	5			25,744		8
9	15	Mgmt. Allocation of Benefits	Resident Days	158,706	5			25,744		9
10	17	Administrative	Resident Days	158,706	5			25,744		10
11	19	Professional Services	Resident Days	158,706	5	146,994		25,744	23,844	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	158,706	5	3,300		25,744	535	12
13	21	Clerical and General Office	Resident Days	158,706	5			25,744		13
14	22	Employee Benefits & Payroll	Resident Days	158,706	5			25,744		14
15	23	Inservice Training & Education	Resident Days	158,706	5			25,744		15
16	24	Travel and Seminar	Resident Days	158,706	5			25,744		16
17	25	Other Admin. Staff Transport.	Resident Days	158,706	5			25,744		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	158,706	5			25,744		18
19	30	Depreciation	Resident Days	158,706	5	7,309		25,744	1,186	19
20	31	Amortization	Resident Days	158,706	5	164,981		25,744	26,762	20
21	32	Interest	Resident Days	158,706	5	229,513		25,744	37,230	21
22	33	Real Estate Taxes	Resident Days	158,706	5			25,744		22
23	34	Rent-Facility and Grounds	Resident Days	158,706	5			25,744		23
24	35	Rent-Equipment & Vehicles	Resident Days	158,706	5			25,744		24
25	TOTALS					\$ 552,097	\$		\$ 89,557	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	\$ 643,463	01/31/17	Varies	\$ 29,714	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 749,900	\$ 643,463			\$ 29,714	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(985)	10	
11								Home Office Allocation-PHCM			401	11	
12								Home Office Allocation-PHC II			37,230	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 36,646	14	
15	TOTALS (line 9+line14)						\$ 749,900	\$ 643,463			\$ 66,360	15	

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swansea Rehab & Hlth Cr Ctr COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0048611

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 08-16.0-409-014	Long-Term Care Facility	\$ 45,948.88	\$ 45,948.88
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 45,948.88	\$ 45,948.88

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

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:

799,059

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

20

3. Current Period Amortization:

26,762

4. Dates Incurred:

2013-2014

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

HFS 3745 (N-4-99)

IL478-2471

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	94		2006	1975	\$ 1,735,000	\$	30	\$ 57,833	\$ 57,833	\$ 607,247
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalk		2006		500		10	50	50	50
10	Landscaping		2007		1,685		15	112	112	112
11	Carpeting		2007		1,637		10	164	164	164
12	Awning		2007		815		10	82	82	82
13	Blinds		2007		1,883		10	188	188	188
14	Signage		2007		2,770		10	277	277	277
15	Roof Top Air Conditioners		2007		16,613		10	1,661	1,661	1,661
16	Landscaping		2008		3,385		15	226	226	226
17	Water Heater		2008		8,724		5			
18	Cable Equipment Installation		2009		7,264		7	1,038	1,038	1,038
19	Water Heater		2010		7,490		10	750	750	750
20	Dining Room Floor		2010		8,638		15	1,152	1,152	1,152
21	Water Heater		2011		3,500		7	500	500	500
22	Water Line Repair		2011		4,822		7	688	688	688
23	Garage		2011		2,770		15	184	184	184
24	Smoke Detection System		2011		7,947		10	1,588	1,588	1,588
25	Water Heater		2012		3,637		7	520	520	520
26	Sprinkler System		2012		119,898		25	4,796	4,796	4,796
27	Water Heater		2014		4,021		7	574	574	574
28	Nurse Call Replacement		2014		9,976		7	1,425	1,425	1,425
29	Sewer Line Replacement		2014		13,300		15	887	887	887
30	Air Conditioner-Kitchen		2016		7,442		15	248	248	248
31	Air Conditioner-Hallway 100		2016		7,280		15	243	243	243
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr

0048611

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63	Land Improvements Booked		1,038			(1,038)		63
64	Building Booked		69,400			(69,400)		64
65	Building Improvement Booked		17,361			(17,361)		65
66								66
67	2016-Home Office Allocation-Building Improvements	11,366			273	273		67
68	2016-Home Office Allocation-Land Improvements	1,046			68	68		68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,993,409	\$ 87,799		\$ 75,527	\$ (12,272)	\$ 624,600	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	\$412,201	\$2,716	\$23,837	\$21,121	5-10 yrs.	\$396,113	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			13,301	13,301			74
75	TOTALS	\$412,201	\$2,716	\$37,138	\$34,422		\$396,113	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	\$	\$	\$		\$28,977
77									
78									
79									
80	TOTALS			\$28,977	\$	\$	\$		\$28,977

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)			\$2,504,587	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$90,515	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$112,665	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$22,150	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$1,049,690	

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		\$	\$	
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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: \$ 30,766 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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</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.

Swansea Rehab & Hlth Cr Ctr
0048611

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

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

Medical Equipment	\$	26,368
Dishwasher		649
Copier		2,640
Home Office Allocation		1,109
		<u>30,766</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	\$	7,556	\$ 113,343	\$	7,556	\$	113,343
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,831	27,468		1,831		27,468
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10A(3)	hrs		8,019	120,288		8,019		120,288
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39(2)	# of prescrpts				49,230			49,230
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify):									
13	Other (specify):									
14	TOTAL			\$	17,406	\$ 261,099	\$ 49,230	17,406	\$	310,329

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	\$ (1,881,602)	\$ (1,881,602)	1
2	Cash-Patient Deposits	5,628	5,628	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 39,840)	2,732,940	2,732,940	3
4	Supply Inventory (priced at Cost)	9,014	9,014	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,628	27,628	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	196,091	196,091	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,089,699	\$ 1,089,699	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	1,746,366	14
15	Leasehold Improvements, at Historical Cost	268,163	247,043	15
16	Equipment, at Historical Cost	441,178	441,178	16
17	Accumulated Depreciation (book methods)	(1,266,016)	(1,049,690)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,253,895	\$ 1,454,897	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,343,594	\$ 2,544,596	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 558,607	\$ 558,607	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,108	91,108	30
31	Accrued Taxes Payable (excluding real estate taxes)	55,030	55,030	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,245	42,245	32
33	Accrued Interest Payable	2,723	2,723	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	5,117	5,117	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 754,830	\$ 754,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	643,463	643,463	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	187,032	187,032	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 830,495	\$ 830,495	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,585,325	\$ 1,585,325	46
47	TOTAL EQUITY(page 18, line 24)	\$ 758,269	\$ 959,271	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,343,594	\$ 2,544,596	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 76,539	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(5,354)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 71,185	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	687,084	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)	\$ 687,084	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)	\$ 758,269	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swansea Rehab & Hlth Cr Ctr

0048611

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,972,257	1
2	Discounts and Allowances for all Levels	(281,562)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,690,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	487,719	6
7	Oxygen	4,016	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 491,735	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,645	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,242	20
21	Other Medical Services	7,632	21
22	Laundry	85	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 90,962	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	985	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 985	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,246	28
28a	<u>Miscellaneous Revenue</u>	1,366	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,612	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,277,989	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	654,724	31
32	Health Care	1,553,006	32
33	General Administration	628,048	33
	B. Capital Expense		
34	Ownership	195,060	34
	C. Ancillary Expense		
35	Special Cost Centers	361,894	35
36	Provider Participation Fee	198,173	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,590,905	40
41	Income before Income Taxes (line 30 minus line 40)**	687,084	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 687,084	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,141,792	44
45	Private Pay - Net Inpatient Revenue	336,887	45
46	Medicare - Net Inpatient Revenue	191,099	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	20,917	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,690,695	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	1,986	1,986	\$ 55,897	\$ 28.15	1
2	Assistant Director of Nursing	809	809	17,823	22.03	2
3	Registered Nurses	2,977	3,042	81,440	26.77	3
4	Licensed Practical Nurses	15,173	15,276	322,203	21.09	4
5	CNAs & Orderlies	45,354	45,822	511,314	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,018	2,082	23,665	11.37	9
10	Activity Assistants					10
11	Social Service Workers	2,073	2,073	31,492	15.19	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,139	14.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,380	10,786	102,082	9.46	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,066	31,018	15.01	17
18	Housekeepers	12,696	13,054	122,477	9.38	18
19	Laundry	3,720	3,759	43,600	11.60	19
20	Administrator	2,080	2,080	89,000	42.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,040	26,488	12.98	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	5,780	6,013	97,869	16.28	33
34	TOTAL (lines 1 - 33)	111,128	112,968	\$ 1,585,507 *	\$ 14.04	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,168	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)		\$ 18,168		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

Swansea Rehab & Hlth Cr Ctr
0048611
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		2,080	2,080	22.83
Restorative Nurse		1,740	1,912	14.38
Transportation		1,960	2,021	11.32
	TOTAL	5,780	6,013	97,869

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Jifi Jacob	Administrator	0	\$ 89,000	Workers' Compensation Insurance	\$ 33,217	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	43,985	Advertising: Employee Recruitment	718		
				FICA Taxes	113,224	Health Care Worker Background Check			
				Employee Health Insurance	9,984	(Indicate # of checks performed 60)	839		
				Employee Meals		Patient Background Checks 41	583		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,535		
				Employee Relations	4,027	Miscellaneous Dues & Subscriptions	2,025		
				Employee Retirement	425	Home Office Allocation	1,098		
				Home Office Allocation	37,358				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,788		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			E. Schedule of Non-Cash Compensation Paid to Owners or Employees		
							G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Charter Communications	Computer Services		\$ 1,198				Out-of-State Travel	\$	
Honkamp, Krueger & Co.	Accounting Services		5,604						
Sorling Northrup	Legal Services		1,150	N/A					
E-Health Data Services	Computer Services		3,783				In-State Travel		
Madison Co Circuit Clerk	Legal Services		60						
							Seminar Expense	95	
							Home Office Allocation	57	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 152	

*** Attach copy of IMRF notifications**

****See instructions.**

Swansea Rehab & Hlth Cr Ctr
0048611
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,795
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	60
Miscellaneous	Legal	20
Miller Hall and Triggs	Legal	104
Healthcare Resources International	Legal	519
Hunziker Law	Legal	124
Lexis Nexis	Legal	11
GoffWilson	Legal	877
Daniel L. Freeland & Associates	Legal	1,053
Illinois Secretary of State	Legal	50
CliftonLarson Allen	Accountants	1,390
Ginoli & Co.	Accountants	4,543
First Merit	Accountants	2,826
Miscellaneous	Computer Services	68
Change Healthcare	Computer Services	10
PTC Select	Computer Services	6
Advanced Answers on Demand	Computer Services	4,741
Stratus Networks	Computer Services	482
Kemper Technology	Computer Services	318
AT&T	Computer Services	7
Ability Network	Computer Services	2,021
CIAN	Computer Services	241
Comcast	Computer Services	39
CCH	Computer Services	16
Charter Communications	Computer Services	47
Allscripts	Computer Services	705
ATS	Computer Services	318
Allpayer Exchange	Computer Services	16
Optimizer	Other Prof Fees	49
Ankura	Other Prof Fees	368
David Budde	Other Prof Fees	42
Bruner, Cooper, Zuck	Other Prof Fees	107
Marotta, Gund, Budd, Dzerda	Other Prof Fees	16,072
Professional Software and Services	Other Prof Fees	26
Hughes Valuation Services	Other Prof Fees	33
Alan Litwiller	Other Prof Fees	2

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

49,106

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IHCA \$2000

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 yrs.

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

\$ 21,134

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.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 198,173

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.

\$ 2,645

(16) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

Yes

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

\$ 2,246

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

100

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

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

Yes

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

Yes

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

No

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

\$ N/A

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

Yes

Firm Name:

Ginoli and Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

No

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

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detr	-313,377	equal to	-313,377	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	66,360	equal to	66,360	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	45,488	equal to	45,488	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	26,762	equal to	26,762	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	112,665	equal to	112,665	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	30,766	equal to	30,766	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	261,099	equal to	261,099	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	49,230	equal to	49,230	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	654,724	equal to	654,724	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,553,006	equal to	1,553,006	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	628,048	equal to	628,048	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	195,060	equal to	195,060	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	361,894	equal to	361,894	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	198,173	equal to	198,173	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,063,673	equal to	1,063,673	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	46,538	equal to	46,538	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	31,492	equal to	31,492	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	131,221	equal to	131,221	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	31,018	equal to	31,018	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	122,477	equal to	122,477	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	43,600	equal to	43,600	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	89,000	equal to	89,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	26,488	equal to	26,488	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,585,507	equal to	1,496,507	89,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	6,168	< or = to	6,462	-294	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	713	-713	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	89,000	equal to	89,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	319,500	equal to	319,500	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	11,795	equal to	11,795	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	242,220	equal to	242,220	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	8,788	equal to	8,788	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	152	equal to	152	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	198,173	equal to	198,173	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	1,192	equal to	1,557	-365	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-793	equal to	-793	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	643,463	equal to	643,463	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	42,245	equal to	42,245	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	70,000	equal to	70,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,993,409	equal to	1,993,409	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	441,178	equal to	441,178	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	1,049,690	equal to	1,049,690	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	758,269	equal to	758,269	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	687,084	equal to	687,084	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,343,594	equal to	2,343,594	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

[illegible]

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	131,221	11,346	-	142,567	0	142,567	5,288	147,855
2. Food Purchase	-	148,131	-	148,131	0	148,131	-2,549	145,582
3. Housekeeping	122,477	35,504	-	157,981	0	157,981	92	158,073
4. Laundry	43,600	13,756	148	57,504	0	57,504	0	57,504
5. Heat and Other Utilities	-	-	88,576	88,576	0	88,576	308	88,884
6. Maintenance	31,018	7,805	21,142	59,965	0	59,965	0	59,965
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	328,316	216,542	109,866	654,724	0	654,724	3,139	657,863
9. Medical Director	-	-	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	#####	130,134	6,462	1,200,269	0	1,200,269	-1,056	#####
10a. Therapy	-	-	261,099	261,099	0	261,099	0	261,099
11. Activities	46,538	157	713	47,408	0	47,408	-2,246	45,162
12. Social Services	31,492	738	-	32,230	0	32,230	0	32,230
13. Nurse Aide Training	-	-	-	0	0	0	0	0
14. Program Transportation	-	-	-	0	0	0	0	0
15. Other (specify)*	-	-	-	0	0	0	0	0
16. Total Health Care & Programs	#####	131,029	280,274	#####	0	1,553,006	-3,302	#####
17. Administrative	-	-	319,500	319,500	0	319,500	-230,500	89,000
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	11,795	11,795	0	11,795	37,311	49,106
20. Fees, Subscriptions & Promotion	-	-	7,690	7,690	0	7,690	1,098	8,788
21. Clerical & General Office	26,488	6,530	16,428	49,446	0	49,446	61,494	110,940
22. Employee Benefits & Payroll	-	-	204,862	204,862	0	204,862	37,358	242,220
23. Inservice Training & Education	-	-	-	0	0	0	118	118
24. Travel and Seminar	-	-	95	95	0	95	57	152
25. Other Admin. Staff Trans	-	-	5,098	5,098	0	5,098	4,850	9,948
26. Insurance-Prop.Liab.Malpractice	-	-	29,562	29,562	0	29,562	683	30,245
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	26,488	6,530	595,030	628,048	0	628,048	-87,531	540,517
29. Total General Administrative	#####	354,101	985,170	2,835,778	0	2,835,778	-87,694	#####
30. Depreciation	-	-	90,515	90,515	0	90,515	22,150	112,665
31. Amortization of Pre-Op. & Org.	-	-	-	0	0	0	26,762	26,762
32. Interest	-	-	29,714	29,714	0	29,714	36,646	66,360
33. Real Estate	-	-	45,174	45,174	0	45,174	314	45,488
34. Rent - Facility & Grounds	-	-	-	0	0	0	0	0
35. Rent - Equipment & Vehicles	-	-	29,657	29,657	0	29,657	1,109	30,766
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	195,060	195,060	0	195,060	86,981	282,041
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	49,230	-	49,230	0	49,230	0	49,230
40. Barber and Beauty Shop	-	-	-	0	0	0	0	0
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	198,173	198,173	0	198,173	0	198,173
43. Other (specify):*	-	22	312,642	312,664	0	312,664	-312,664	0
44. Total Special Cost Ce	-	49,252	510,815	560,067	0	560,067	-312,664	247,403
45. Grand Total	#####	403,353	#####	#####	0	3,590,905	-313,377	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#####	-1,881,602
2. Cash - Patient Deposits	5,628	5,628
3. Accounts & Notes Recievable	2,732,940	2,732,940
4. Supply Inventory	9,014	9,014
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,628	27,628
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	196,091	196,091
10. Total current assets	1,089,699	1,089,699
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	75,570	70,000
14. Buildings, at Historical Cost	1,735,000	1,746,366
15. Leasehold Improvements, Historical Cost	268,163	247,043
16. Equipment, at Historical Cost	441,178	441,178
17. Accumulated Depreciation (book methods) #####		-1,049,690
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,253,895	1,454,897
25. Total Assets	2,343,594	2,544,596
CURRENT LIABILITIES		
26. Accounts Payable	558,607	558,607
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	91,108	91,108
31. Accrued Taxes Payable	55,030	55,030
32. Accrued Real Estate Taxes	42,245	42,245
33. Accrued Interest Payable	2,723	2,723
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	5,117	5,117
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	754,830	754,830
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	643,463	643,463
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	187,032	187,032
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	830,495	830,495
46.Total Liabilities	1,585,325	1,585,325
47.Total Equity	758,269	959,271
48.Total Liabilities and Equity	2,343,594	2,544,596

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,972,257
2. Discounts and Allowances for all Levels	-281,562
Subtotal - Inpatient Care	3,690,695
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	487,719
7. Oxygen	4,016
Subtotal - Ancillary Revenue	491,735
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,645
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	74,358
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	6,242
21. Other Medical Services	7,632
22. Laundry	85
Subtotal - Other Operating Revenue	90,962
24. Contributions	0
25. Interest and Other Investments Income	985
Subtotal - Non-Operating Revenue	985
27. Other Revenue (specify):	2,246
28. Other Revenue (specify):	1,366
Subtotal - Other Revenue	3,612
30. Total Revenue	4,277,989
31. General Services	646,418
32. Health Care	1,628,521
33. General Administration	670,910
34. Ownership	182,292
35. Special Cost Centers	92,146
35. Provider Participation Fee	189,376
37. Other	0
40. Total Expenses	3,409,663
41. Income Before Income Taxes	868,326
42. Income Taxes	0
43. Net Income or Loss for the Year	868,326