

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0035485 Facility Name: Swann Special Care Center Address: 109 Kenwood Road Champaign 61821 County: Champaign Telephone Number: (217) 356-5164 Fax #: (217) 356-7873 HFS ID Number: Date of Initial License for Current Owners: 08-15-1989 Type of Ownership: ☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501 (c)(3) ☐ PROPRIETARY ☐ 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: Douglass Smith

Telephone Number: (615) 647-9004 Ext. 701

Email Address:

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

No change

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>45,018</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>45,018</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>41,653</u>	<u>390</u>	<u>137</u>	<u>42,180</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,653</u>	<u>390</u>	<u>137</u>	<u>42,180</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.70%

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

58 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

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

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 08/15/1989

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

YES

☒

Date 08/15/1989

NO

☐

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

YES

☐

NO

☒

If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2019 Ending: 06/30/2020
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	277,439	13,379	14,967	305,785		305,785	(81,502)	224,283			1
2	Food Purchase		175,948		175,948		175,948	(82,773)	93,175			2
3	Housekeeping		11,514	38,528	50,042		50,042	(14,777)	35,265			3
4	Laundry	28,362	14,980	113,002	156,344		156,344		156,344			4
5	Heat and Other Utilities			84,374	84,374		84,374	(6,951)	77,423			5
6	Maintenance	206,268	43,238	177,409	426,915		426,915	(154,935)	271,980			6
7	Other (specify):*											7
8	TOTAL General Services	512,069	259,059	428,280	1,199,408		1,199,408	(340,938)	858,470			8
	B. Health Care and Programs											
9	Medical Director			69,000	69,000		69,000		69,000			9
10	Nursing and Medical Records	3,272,703	347,992	2,981	3,623,676		3,623,676	(334,813)	3,288,863			10
10a	Therapy		64,414	129,077	193,491		193,491	(69,475)	124,016			10a
11	Activities	220,519	1,134	632	222,285		222,285		222,285			11
12	Social Services			437	437		437		437			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,493,222	413,540	202,127	4,108,889		4,108,889	(404,288)	3,704,601			16
	C. General Administration											
17	Administrative					141,182	141,182	64,118	205,300			17
18	Directors Fees			106,103	106,103		106,103	(30,911)	75,192			18
19	Professional Services			718,065	718,065		718,065	(467,745)	250,320			19
20	Dues, Fees, Subscriptions & Promotions			30,104	30,104		30,104	(17,560)	12,544			20
21	Clerical & General Office Expenses	266,528	9,690	149,017	425,235	(141,182)	284,053	(96,518)	187,535			21
22	Employee Benefits & Payroll Taxes			872,323	872,323		872,323	(188,559)	683,764			22
23	Inservice Training & Education			17,485	17,485		17,485	(5,323)	12,162			23
24	Travel and Seminar			3,025	3,025		3,025	12,669	15,694			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			269,698	269,698		269,698	(65,866)	203,832			26
27	Other (specify):*											27
28	TOTAL General Administration	266,528	9,690	2,165,820	2,442,038		2,442,038	(795,695)	1,646,343			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,271,819	682,289	2,796,227	7,750,335		7,750,335	(1,540,921)	6,209,414			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Swann Special Care Center #0035485 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation							133,953	133,953			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,732	4,732		4,732	183,408	188,140			32
33	Real Estate Taxes			15,745	15,745		15,745	(15,745)				33
34	Rent-Facility & Grounds			602,213	602,213		602,213	(593,392)	8,821			34
35	Rent-Equipment & Vehicles			22,545	22,545		22,545	(8,890)	13,655			35
36	Other (specify):*							34,700	34,700			36
37	TOTAL Ownership			645,235	645,235		645,235	(265,966)	379,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,227	15,271	32,498		32,498	(20,558)	11,940			39
40	Barber and Beauty Shops			(205)	(205)		(205)		(205)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			537,152	537,152		537,152		537,152			42
43	Other (specify):* DT/ EDU	1,318,871	2,815	404,261	1,725,947		1,725,947	(1,725,947)				43
44	TOTAL Special Cost Centers	1,318,871	20,042	956,479	2,295,392		2,295,392	(1,746,505)	548,887			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,590,690	702,331	4,397,941	10,690,962		10,690,962	(3,553,392)	7,137,570			45

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

Schedule V Line 23 Detailed Schedule

Purpose of Seminar	Name of Attendee	Title of Attendee	Expense Amount
Relias Learning	All Employees	Various	12,017
CPE/AED Training - In-Pulse	Various	Various	1,798
Tuition Reimbursement	Beverly Ellazar	Administrative Assistant	2,500
Food Service Certification Course	Various	Food Service Manager	405 *
2019 conference - Improving Special Education Services for Students with Complex Needs	John Lawrence	Education - Teacher	395
Asbestos Designated Person Training	John Lawrence	Education - Teacher	245
INHAA-Annual Conference	Kym Halberstadt	Administrator	125
Line 23 Column 4 Total			17,485
Line 23 Column 7 Adjustment - Corporate/Home Office Allocated Costs			757
Line 23 Column 6 Total			18,242
Non-allowable Amounts above removed through Sch 5 Adjustments:			
Non-care related amounts noted above (Page 5A)			(405) *
Allocation for non-care related education and day training (see Page 11.2 & Page 5A)			(5,675)
Line 23 Column 8 Total			12,162
			-

Facility Name & ID Number

Swann Special Care Cent

0035485

Report Period 07/01/2019

Ending:

06/30/2020

Schedule V - Reclassification Summary

Description	Increase/Decrease	Sch. V Line/Col
Reclassification of Administrator Wages:		
Administrative	141,182	17 / 5
Clerical & General Office Expenses	(141,182)	21 / 5

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (1,725,947)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(35,877)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,456)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(15,240)	21		17
18	Fines and Penalties	(1,090)	20		18
19	Entertainment				19
20	Contributions	(323)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,172)	20		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	(1,423,425)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,217,530)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(335,862)	19, 34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (335,862)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,553,392)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Interest Expense - Late Fees	\$ (118)	32	1
2	Non-Allowable Lobby Offset	(1,885)	20	2
3	Advertising	(826)	21	3
4	Non-Allowable Depreciation Expense	(61,778)	30	4
5	Non-Allowable Portion of Inservice Training/Edu	(405)	23	5
6	Non-Allowable Portion of Travel/Seminar	(263)	24	6
7	Flowers	(518)	21	7
8	Unallowable Day Trng EDU Alloc - Dietary	(81,502)	1	8
9	Unallowable Day Trng EDU Alloc - Food	(46,896)	2	9
10	Unallowable Day Trng EDU Alloc - Hskpg	(14,777)	3	10
11	Unallowable Day Trng EDU Alloc - Maint	(155,073)	6	11
12	Unallowable Day Trng EDU Alloc - Nursing	(334,813)	10	12
13	Unallowable Day Trng EDU Alloc - Therapy	(69,475)	10a	13
14	Unallowable Day Trng EDU Admin Alloc	(45,825)	17	14
15	Unallowable Day Trng EDU	(30,911)	18	15
16	Unallowable Day Trng EDU Prof Svcs Alloc	(118,373)	19	16
17	Unallowable Day Trng EDU Dues/Fees Alloc	(9,266)	20	17
18	Unallowable Day Trng EDU Clerical Alloc	(72,291)	21	18
19	Unallowable Day Trng EDU EE Ben Alloc	(207,120)	22	19
20	Unallowable Day Trng EDU Insrv/Trn Alloc	(5,675)	23	20
21	Unallowable Day Trng EDU Travel/Seminar Alloc	(448)	24	21
22	Unallowable Day Trng EDU Insur Alloc	(109,164)	26	22
23	Unallowable Day Trng EDU Rent Equip Alloc	(9,227)	35	23
24	Unallowable Day Trng EDU Ancillary Alloc	(20,558)	39	24
25	Property Tax paid for Offsite Rental Space	(15,745)	33	25
26	Miscellaneous Income	(7,808)	21	26
27	Refund	(2,685)	21	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	(1,423,425)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	(81,502)	0	0	0	0	0	0	0	0	0	0	(81,502)	1
2	Food Purchase	(82,773)	0	0	0	0	0	0	0	0	0	0	(82,773)	2
3	Housekeeping	(14,777)	0	0	0	0	0	0	0	0	0	0	(14,777)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,456)	0	1,505	0	0	0	0	0	0	0	0	(6,951)	5
6	Maintenance	(155,073)	0	138	0	0	0	0	0	0	0	0	(154,935)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(342,581)	0	1,643	0	0	0	0	0	0	0	0	(340,938)	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	(334,813)	0	0	0	0	0	0	0	0	0	0	(334,813)	10
10a	Therapy	(69,475)	0	0	0	0	0	0	0	0	0	0	(69,475)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	(404,288)	0	0	0	0	0	0	0	0	0	0	(404,288)	16
	C. General Administration													
17	Administrative	(45,825)	0	109,943	0	0	0	0	0	0	0	0	64,118	17
18	Directors Fees	(30,911)	0	0	0	0	0	0	0	0	0	0	(30,911)	18
19	Professional Services	(118,373)	0	(358,719)	9,347	0	0	0	0	0	0	0	(467,745)	19
20	Fees, Subscriptions & Promotions	(19,413)	0	1,853	0	0	0	0	0	0	0	0	(17,560)	20
21	Clerical & General Office Expenses	(99,691)	0	3,173	0	0	0	0	0	0	0	0	(96,518)	21
22	Employee Benefits & Payroll Taxes	(207,120)	0	18,561	0	0	0	0	0	0	0	0	(188,559)	22
23	Inservice Training & Education	(6,080)	0	757	0	0	0	0	0	0	0	0	(5,323)	23
24	Travel and Seminar	(711)	0	13,380	0	0	0	0	0	0	0	0	12,669	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(109,164)	0	1,810	41,488	0	0	0	0	0	0	0	(65,866)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(637,288)	0	(209,242)	50,835	0	0	0	0	0	0	0	(795,695)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,384,157)	0	(207,599)	50,835	0	0	0	0	0	0	0	(1,540,921)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(61,778)	0	833	194,898	0	0	0	0	0	0	0	133,953	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(118)	0	0	183,526	0	0	0	0	0	0	0	183,408	32
33	Real Estate Taxes	(15,745)	0	0	0	0	0	0	0	0	0	0	(15,745)	33
34	Rent-Facility & Grounds	0	0	8,821	(602,213)	0	0	0	0	0	0	0	(593,392)	34
35	Rent-Equipment & Vehicles	(9,227)	0	337	0	0	0	0	0	0	0	0	(8,890)	35
36	Other (specify):*	0	0	0	34,700	0	0	0	0	0	0	0	34,700	36
37	TOTAL Ownership	(86,868)	0	9,991	(189,089)	0	0	0	0	0	0	0	(265,966)	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	(20,558)	0	0	0	0	0	0	0	0	0	0	(20,558)	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):*	(1,725,947)	0	0	0	0	0	0	0	0	0	0	(1,725,947)	43
44	TOTAL Special Cost Centers	(1,746,505)	0	0	0	0	0	0	0	0	0	0	(1,746,505)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,217,530)	0	(197,608)	(138,254)	0	0	0	0	0	0	0	(3,553,392)	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
<u>Hoosier Care, Inc.</u>	<u>100</u>	<u>Walter Lawson Children's Home</u>	<u>Loves Park, IL</u>	<u>Champaign Facility Co</u>	<u>Champaign, IL</u>	<u>Property Co.</u>
		<u>Exceptional Care & Training Center</u>	<u>Sterling, IL</u>	<u>Hoosier Care Investme</u>	<u>Nashville, TN</u>	<u>NFP Affiliated Co.</u>
		<u>Exceptional Living of Brazil</u>	<u>Brazil, IN</u>	<u>Medical Rehabilitation</u>	<u>Lexington, KY</u>	<u>Mgmt Co.</u>
		<u>Richland-Bean Blossom Health Care</u>	<u>Ellettsville, IN</u>	<u>Grace Financial Servic</u>	<u>Chattanooga, TN</u>	<u>Mgmt Co.</u>
		<u>Vernon Manor Children's Home</u>	<u>Wabash, IN</u>			
		<u>Randolph Nursing Home</u>	<u>Winchester, IN</u>			

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	18	<u>Group Mgmt/Dir Fees</u>	<u>\$ 106,103</u>	<u>Hoosier Care, Inc.</u>	<u>100.00%</u>	<u>\$ 106,103</u>	<u>\$</u>	<u>1</u>
2	V				<u>Note: See Schedule VII Section C for description.</u>				<u>2</u>
3	V								<u>3</u>
4	V								<u>4</u>
5	V								<u>5</u>
6	V								<u>6</u>
7	V		<u>PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6A)</u>						<u>7</u>
8	V								<u>8</u>
9	V								<u>9</u>
10	V								<u>10</u>
11	V								<u>11</u>
12	V								<u>12</u>
13	V								<u>13</u>
14	Total			<u>\$ 106,103</u>			<u>\$ 106,103</u>	<u>\$ *</u>	<u>14</u>

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Rel. Party Management Fee	\$ 375,104	Medical Rehabilitation Centers, LLC	37.50%	\$	\$ (375,104)	15
16	V			dba Exceptional Living Centers				16
17	V			Hoosier Care owns a beneficial interest in MRC				17
18	V			Note: Please see Schedule VIII for detail of Column 7.				18
19	V	5 Related Party Utilities				1,505	1,505	19
20	V	6 Related Party Maintenance				138	138	20
21	V	17 Related Party Administrative				109,943	109,943	21
22	V	19 Related Party Professional Services				16,385	16,385	22
23	V	20 Related Party Dues, Fees, Subscriptions				1,853	1,853	23
24	V	21 Related Party Clerical & General Office				3,173	3,173	24
25	V	22 Related Party Employee Benefits & Payoll Taxes				18,561	18,561	25
26	V	23 Related Party Inservice Training & Education				757	757	26
27	V	24 Related Party Travel & Seminar				13,380	13,380	27
28	V	25 Related Party Other Admin Staff Transportation						28
29	V	26 Related Party Insurance				1,810	1,810	29
30	V	30 Related Party Depreciation				833	833	30
31	V	32 Related Party Interest						31
32	V	34 Related Party Rent - Facility & Grounds				8,821	8,821	32
33	V	35 Related Party Rent - Equipment				337	337	33
34	V							34
35	V							35
36	V	PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6B)						36
37	V							37
38	V							38
39	Total		\$ 375,104			\$ 177,496	\$ * (197,608)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rel. Party Bldg/Equip Rent	\$ 602,213	Champaign Facility Company, LLC	100.00%	\$	\$ (602,213)	15
16	V			This facility company is under 100% common ownership				16
17	V			with SSCC, and therefore the "rent" paid to the facility				17
18	V			company has been removed from this report and the				18
19	V			actual expenses of the facility company have been				19
20	V			added here:				20
21	V	30 Related Party Depreciation		Champaign Facility Company, LLC		194,898	194,898	21
22	V	32 Related Party Interest		Champaign Facility Company, LLC		176,294	176,294	22
23	V	32 Related Party Amortization of Debt Cost		Champaign Facility Company, LLC		7,232	7,232	23
24	V	26 Related Party Insurance		Champaign Facility Company, LLC		41,488	41,488	24
25	V	36 Related Party Mortgage Insurance		Champaign Facility Company, LLC		34,700	34,700	25
26	V	19 Related Party Accounting Fees		Champaign Facility Company, LLC		9,347	9,347	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	PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6C)						37
38	V							38
39	Total		\$ 602,213			\$ 463,959	\$ * (138,254)	39

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

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			Churchman Village	Newark, DE				1
2			Harbor Health Care	Lewes, DE				2
3			Parkview Nursing	Wilmington, DE				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Foos	Board Member	Governance	0.00					\$		1
2	John Gilmor	Board Member	Governance	0.00							2
3	Jim Ridenour	Board Member	Governance	0.00							3
4	Jo Anne Corbitt	Board Member	Governance	0.00							4
5	Douglass Smith	Board Member	Governance	0.00							5
6	Stephen Wood	Board Member	Governance	0.00							6
7	Laura Hawken	Board Member	Governance	0.00							7
8	Note: Fees are paid by SSCC to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-profit) which go toward fees for members of the Board of Directors of HCI										8
9	affiliated facilities, Swann Special Care Center being one of many. Therefore no Board Fees or compensation paid directly by SSCC to the Directors, but rather										9
10	the fees paid by SSCC to HCI are combined with similar fees paid by other facilities, for HCI to provided governance and managerial oversight, including payment by HCI										10
11	to Board members of each legal entity. Fees paid by other IL facilities are shown on Page 7.1										11
12	The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the facility:							Admin Fees	106,103	18.8	12
13								TOTAL	\$ 106,103		13

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

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

VII. RELATED PARTIES (continued)

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

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

Amounts Paid for Directors/Administration Fees by other Nursing Homes

Walter Lawson Children's Home	86,108
Swann Special Care Center	106,103
Exceptional Care & Training Center	72,542

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Medical Rehabilitation Centers, LLC dba Excepti
Street Address 1050 Chinoe Road, Suite 350
City / State / Zip Code Lexington, KY 40502
Phone Number (859) 255-0075
Fax Number (859) 571-5150

	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,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Direct Cost	117,678,712	17	\$ 25,767	\$	6,871,153	\$ 1,505	1
2	6	Maintenance	Direct Cost	117,678,712	17	2,368		6,871,153	138	2
3	17	Administrative	Direct Cost	117,678,712	17	1,882,943		6,871,153	109,943	3
4	19	Professional Services	Direct Cost	117,678,712	17	280,616		6,871,153	16,385	4
5	20	Dues, Fees, Subscriptions	Direct Cost	117,678,712	17	31,731		6,871,153	1,853	5
6	21	Clerical & General Office	Direct Cost	117,678,712	17	54,346		6,871,153	3,173	6
7	22	Employee Benefits & Payroll Taxes	Direct Cost	117,678,712	17	317,893		6,871,153	18,561	7
8	23	Inservice Training & Education	Direct Cost	117,678,712	17	12,961		6,871,153	757	8
9	24	Travel & Seminar	Direct Cost	117,678,712	17	229,152		6,871,153	13,380	9
10	26	Insurance	Direct Cost	117,678,712	17	31,001		6,871,153	1,810	10
11	30	Depreciation	Direct Cost	117,678,712	17	14,264		6,871,153	833	11
12	32	Interest	Direct Cost	117,678,712	17			6,871,153	0	12
13	34	Rent - Facility & Grounds	Direct Cost	117,678,712	17	151,069		6,871,153	8,821	13
14	35	Rent - Equipment	Direct Cost	117,678,712	17	5,767		6,871,153	337	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,039,878	\$		\$ 177,496	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related OrganizationMedical Rehabilitation Centers, LLC dba Exceptional Living Centers

Medical Rehabilitation Centers, LLC (dba Exceptional Living Centers)
Nine Months Ended March 31 2020

This facility allocation determines the percentage of allowable ELC expenses by building based on the % of each building's operating expenses compared to the total of operating expenses for all facilities under management.

Determination of % of Costs to be allocated to each facility under management: % of total Operating Direct Costs of the Facility to all Facilities under Mgmt

Facility	Operating Expense 07/19 - 03/20	Facility GL Mgmt Fee 07/19 - 03/20	Percent Alloc.	Actual Costs
1 Allis Care Center	10,243,689		8.70%	316,866
2 Exceptional Senior Living (Prospect)	1,688,153	108,440	1.43%	52,219
Total LHM	11,931,843		10.14%	369,086
3 Century Villa	5,242,689	397,397	4.46%	162,171
Subtotal Putnam Co Facilities	5,242,689		4.46%	162,171
4 Morning Breeze	3,932,363	143,690	3.34%	121,639
Subtotal AE Indiana Facilities	3,932,363		3.34%	121,639
5 Sanders Glen	1,862,308	186,545	1.58%	57,606
Subtotal QSH Facilities	1,862,308		1.58%	57,606
6 ELC Brazil	3,970,880	470,460	3.37%	122,831
7 Towne Park	709,086	43,965	0.60%	21,934
8 Randolph Nursing	4,279,507	327,528	3.64%	132,377
9 Richland Bean-Blossom	3,903,396	361,260	3.32%	120,743
10 Vernon Manor	4,895,315	357,702	4.16%	151,426
Subtotal ESG Indiana Facilities	17,756,185		15.09%	549,311
11 Exceptional Care Training Center	4,285,487	309,726	3.64%	132,562
12 Swann Special Care Center	6,871,153	449,172	5.84%	212,544
13 Walter Lawson	5,914,103	399,429	5.03%	182,940
Subtotal ESG Illinois Facilities	17,070,743		14.51%	528,046
14 Harbor	11,390,362	996,870	9.68%	352,336
15 Parkview	9,555,347	816,792	8.12%	295,574
16 Churchman	7,810,714	723,780	6.64%	241,607
Subtotal ESG East	28,756,423		24.44%	889,517
Total Hoosier Care	63,585,350		54.03%	1,966,874
17 Clifton Oaks Care Center	3,280,171	62,298	2.79%	101,465
18 Frankfort Care & Rehab	3,172,657	51,756	2.70%	98,139
19 Green Hill Rehab & Care	2,853,247	62,529	2.42%	88,259
20 Hillcreek Rehab & Care	4,566,816	76,344	3.88%	141,265
21 Kirtland Rehab & Care	3,305,980	66,452	2.91%	102,263
22 Lyndon Woods Care	3,537,929	65,687	3.01%	109,438
23 St Matthews Care Center	4,176,317	79,974	3.55%	129,185
24 Stanford Care & Rehab	3,698,724	67,414	3.14%	114,412
25 Vanceburg Rehab & Care	2,532,319	62,902	2.15%	79,332
Subtotal KYOH Group	31,124,159		26.45%	962,758
Total ELC Facilities Under Mgmt	117,678,712		100.00%	3,640,135

ILLINOIS			SSCC SNF	
CR Line		Total for CR Line	SSCC Allowable	Only (84%)
5	Utilities	30,855	1,802	25,767
6	Maintenance	2,835	166	2,368
17	Administrative	2,254,751	131,653	1,882,943
19	Professional Services	336,027	19,620	280,616
20	Dues, Fees, Subscriptions	37,997	2,219	31,731
21	Clerical & General Office	65,077	3,800	54,346
22	Employee Benefits & Payroll Taxes	380,664	22,227	317,893
23	Inservice Training & Education	15,520	906	12,961
24	Travel & Seminar	274,401	16,022	229,152
25	Other Admin Staff Transportation	-	-	-
26	Insurance	37,123	2,168	31,001
30	Depreciation	17,080	997	14,264
32	Interest	-	-	-
34	Rent - Facility & Grounds	180,899	10,563	151,069
35	Rent - Equipment	6,906	403	5,767
		3,640,135	212,544	3,039,876

To CR PG6 Col 6 total indirect cost being allocated

Gross GL Rel Pty Mgmt Fee Expense	SNF	EDU/DT	SNF	EDU/DT
449,172	375,104	74,068	84%	16%

Amts removed via EDU/DT Adj CR PG5A for L19 (See DT/EDU Alloc WP 2035 for % offset)

177,496 Allowable cost of Rel Pty Mgmt Co to now be reclassified to functional expense lines below

Swann Special Care Center			Percentage of grouped (Amt to reclass to CR Lines	
IL CR Line				
5	Utilities	0.85%	1,505	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
6	Maintenance	0.08%	138	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
17	Administrative	61.94%	109,943	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
19	Professional Services	9.23%	16,385	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
20	Dues, Fees, Subscriptions	1.04%	1,853	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
21	Clerical & General Office	1.79%	3,173	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
22	Employee Benefits & Payroll Taxes	10.46%	18,561	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
23	Inservice Training & Education	0.43%	757	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
24	Travel & Seminar	7.54%	13,380	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
25	Other Admin Staff Transportation	0.00%	-	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
26	Insurance	1.02%	1,810	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
30	Depreciation	0.47%	833	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
32	Interest	0.00%	-	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
34	Rent - Facility & Grounds	4.97%	8,821	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
35	Rent - Equipment	0.19%	337	To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
		100.00%	177,496	

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	11/01/12	\$ 8,377,500	\$ 6,838,260	11/01/42	0.0254	\$ 176,294	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	GE Healthcare Finance		X	Working Capital		06/24/14	5,750,000		1/27/19	Variable		6	
7												7	
8												8	
9	TOTAL Facility Related				\$33,276.00		\$ 14,127,500	\$ 6,838,260			\$ 176,294	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	\$ 6,838,260			\$ 176,294	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,700 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	8		
	2016	9		
	2017	10		
	2018	11		
	2019	12		
Note: This facility became exempt from Property Taxes starting on 1/1/1996				

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(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. <u>TAX EXEMPT</u>		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

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.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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 offsite; cost removal adjustments & allocation to remove associated costs shown on Sch V and further explanation on PG 11.2

Swann Development Day Training Program, operated offsite; 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

Schedule X Supplemental Schedule**Item 14 - Allocation of non-long term care costs**

- (E) Swann Special Center operates Education and Developmental Day Training programs in dedicated space 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 43 of Schedule V, "Other Costs 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 Day Training programs are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

Costs incurred which benefit multiple operation programs are identified, segregated, and reported each year in conjunction with required cost report filings to the Illinois Purchased Care Review Board for the Education 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:

07/01/2019

Ending:

06/30/2020

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		\$ 2,080,835
5	9			1993	N/A					
6	8			1996	N/A					
7	8			2000	N/A					
8	11			2004	N/A					
	Improvement Type**									
9	FIRE DOORS			7/16/1990	2,751		10			2,751
10	FIRE DOORS			6/20/1991	3,675		10			3,675
11	SPRINKLER/EXIT DEVICES OD			1/30/1992	3,162		10			3,162
12	ROOFING			12/4/1992	3,900		10			3,900
13	SPRINKLER SYSTEM			3/30/1993	14,460		10			14,460
14	FIRE DOORS, CLOSETS, TILE			11/1/1993	5,225		10			5,225
15	HOODS, FANS, ANSUL SYSTEM			3/14/1993	2,500		10			2,500
16	WORK FOR EXHAUST FAN & HO			4/6/1995	3,995		10			3,995
17	WALK-IN COOLER			10/24/1995	3,334		10			3,334
18	REPLACE 2 ROOFTOP HVAC UN			12/7/1998	17,650		10			17,650
19	BALANCE-INSTALL ALARM SYS			6/29/2000	2,730		5			2,730
20	INSTALL CLINICAL SINK.			7/18/2000	3,030		5			3,030
21	INSTALL DOORS AT KENWOOD			7/18/2000	4,028		15			4,028
22	REPLACE GATE VALVE/INSTAL			9/8/2000	6,005		15			6,005
23	NEW FLOOR DRAINS IN SHOWE			1/24/2001	3,180		15			3,180
24	INSTALL SHOWER DRAINS			7/16/2001	10,500	525	20	525		9,975
25	REPLACE DOORS			1/2/2002	3,000		5			3,000
26	INTERNET SET-UP-WIRING, C			2/21/2002	6,141		5			3,165
27	SECURITY SYSTEM			2/21/2002	3,165		15			6,141
28	INSTALL TWO SINKS			5/13/2002	3,561		5			3,561
29	INSTALL A/C ROOFTOP UNIT			8/26/2002	8,237		15			8,237
30	CENTRAL HEAT/AIR ROOFTOP			1/22/2003	5,180		15			5,180
31	ROOFTOP UNIT INSTALLED; HEAT/AIR WING 3			7/31/2003	10,910		15			10,910
32	ROOFING PROJECT-WING 1,2,4 (23318.33+431			6/8/2005	66,485	4,063	15	4,063		66,485
33	RE-TILE SHOWER ROOM			4/27/2006	10,714	714	15	714		10,119
34	DEPOSIT FOR DURO LAST ROOF			7/13/2006	10,000	667	15	667		9,333
35	DURO LAST ROOF - PAYMENT #2			7/13/2006	4,384	292	15	292		4,092
36	100 AMP SUB PANEL			9/25/2006	2,650	177	15	177		2,429

*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:

07/01/2019 Ending: 06/30/2020

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	
37	RE-TILE SHOWER ROOM #10	9/27/2006	\$ 11,642	\$ 776	15	\$ 776	\$	\$ 10,672	37
38	REPLACE WALLS IN DISHWASHER AREA	12/5/2006	7,477	498	15	498		6,771	38
39	RE-TILE SHOWER ROOM #3	12/15/2006	11,642	776	15	776		10,542	39
40	RE-TILE SHOWER ROOM #4	12/28/2006	11,642	776	15	776		10,478	40
41	RE-TILE SHOWER ROOM #'S 5,6,7	3/15/2000	12,746	850	15	850		11,330	41
42	REPLACE MOTORS ON ROOF EXHAUST FANS(7)	8/7/2007	2,667		10			2,667	42
43	UPGRADE LIGHTING SYSTEM IN EDUCATION BLDG	8/21/2007	6,501	433	15	433		5,562	43
44	RE-TILE TEAM 6 BATHROOM	8/29/2007	7,561	504	15	504		6,469	44
45	WIRE BREAKROOM & OUTLETS FOR NURSES STATION	12/4/2007	2,574	172	15	172		2,160	45
46	REPLACE 2 DOORS IN LAUNDRY AREA	2/29/2008	4,187	279	15	279		3,443	46
47	REMODEL CONF ROOM (CABINETS, COUNTERS, ETC.)	7/10/2008	2,536		10			2,536	47
48	ADDITIONAL OUTLETS IN ROOMS 5,6,7,8,9	12/4/2008	7,625	508	15	508		5,888	48
49	COMPRESSOR FOR A/C UNIT	9/11/2009	2,830	47	10	47		2,830	49
50	INDUCT AIR PURIFIERS	12/14/2009	3,638	152	10	152		3,638	50
51	OUTLETS IN RESIDENT ROOMS	10/9/2010	12,618	841	15	841		8,202	51
52	OUTLETS IN ROOMS 3B/1B,5A,6A,5B,6B	12/16/2010	8,280	552	15	552		5,244	52
53	OUTLETS IN ROOMS 7A/7B/13/14/17/11B/12A	1/24/2011	13,800	920	15	920		8,663	53
54	COMPRESSOR & BLOWER WHEEL	6/28/2011	2,575	258	10	258		2,318	54
55	SPRINKLERS FOR EXT EAVES ON WEST WING	9/20/2011	4,275	428	10	428		3,741	55
56	TILE FLOORS & WALLS FOR BATHROOMS	11/29/2011	19,854	1,324	15	1,324		11,361	56
57	HEAT EXHANGER	12/12/2011	4,035	404	10	404		3,463	57
58	NETWORK DROPS FOR PAIGE II	12/13/2011	2,550	255	10	255		2,189	58
59	HEAT EXHANGER	3/16/2012	6,570	657	10	657		5,420	59
60	RENOVATE SHOWER ROOMS #2/14/15	4/23/2012	19,500	1,300	15	1,300		10,617	60
61	WEATHERIZATION PROJECT	7/1/2012	3,099	310	10	310		2,479	61
62	FLOORING FOR SHOWER ROOM	10/18/2012	6,000	600	10	600		4,600	62
63	EXTERIOR PAINTING & WATERPROOFING	10/26/2012	9,752	650	15	650		4,984	63
64	EMERGENCY GENERATOR	2/28/2013	63,610	4,241	15	4,241		31,098	64
65	IDPH ELECTRICAL WORK	5/1/2013	32,000	2,133	15	2,133		15,289	65
66	NEW FLOORING INSTALLED	5/1/2013	6,133	409	15	409		2,930	66
67	NEW FLOORING INSTALLED	5/13/2013	6,000	400	15	400		2,867	67
68	IDPH ELECTRICAL WORK	6/25/2013	17,855	1,190	15	1,190		8,332	68
69	DRAIN TILE INSTALLATION	10/23/2013	11,897	1,190	10	1,190		7,931	69
70	TOTAL (lines 4 thru 69)		\$ 3,162,223	\$ 86,546		\$ 86,546	\$	\$ 2,529,801	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:

07/01/2019 Ending: 06/30/2020

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		\$ 3,162,223	\$ 86,546		\$ 86,546		\$ 2,529,801	1
2	SECURITY SYSTEM FOR FRONT DOOR	3/5/2014	3,547	355	10	355		2,246	2
3	MOP ROOM RENOVATION	4/14/2014	3,520	352	10	352		2,200	3
4	MOP ROOM RENOVATION	4/15/2014	4,636	464	10	464		2,897	4
5	THERAPURE TUB	8/26/2014	12,038	1,204	10	1,204		7,022	5
6	WHIRLPOOL ROOM FLOORING	8/27/2014	4,300	430	10	430		2,508	6
7	TEAM 8 SHOWER ROOM FLOORING	2/17/2015	7,600	760	10	760		4,053	7
8	HVAC UNIT	6/1/2016	5,755	576	10	576		2,350	8
9	HVAC UNIT	7/8/2016	10,975	1,098	10	1,098		4,390	9
10	NURSE CALL SYSTEM - 50% DOWN PMT	3/27/2017	20,500	2,050	10	2,050		6,662	10
11	BLINDS INSTALLED	5/26/2017	7,203	720	10	720		2,221	11
12	NURSE CALL SYSTEN - FINAL PMT	6/29/2017	20,042	2,004	10	2,004		6,013	12
13	STAFF ASSIST BUTTOM SYSTEM INSTALLED	7/11/2017	2,800	280	10	280		840	13
14	BREAK ROOM REMODEL	11/22/2017	11,325	1,130	10	1,130		2,926	14
15	CHAIN LINK FENCE	1/18/2018	2,550	255	10	255		616	15
16	FENCE/DUMPSTER ENCLOSURE	12/16/2006	2,750		10			2,750	16
17	INSTALL DRAINING SYSTEM IN COURTYARD	2/2/2004	9,268		7			9,268	17
18	PARKING LOT/DUMPSTER PAD REPAVED	10/20/2006	8,073		10			8,073	18
19	REPLACE UNDERGROUND FUEL	11/11/1998	9,223		20			9,223	19
20	RE-SEAL AND RE-STRIPE PARKING LOT	7/1/2002	2,810		10			2,810	20
21	RESURFACE PARKING LOT	11/1/1993	19,115		10			19,115	21
22	RESURFACE PARKING LOT 50%	8/31/2017	8,610	861	10	861		2,440	22
23	RESURFACE PARKING LOT FINAL PMT	8/31/2017	9,125	912	10	912		2,585	23
24	TANK REMOVAL	7/1/2016	7,750	775	10	775		3,100	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,355,738	\$ 100,772		\$ 100,772		\$ 2,636,109	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	\$163,628	\$26,439	\$26,439	\$	5-7	\$84,030	71
72	Current Year Purchases	43,666	3,333	3,333		5	3,333	72
73	Fully Depreciated Assets	824,653	2,576	2,576		5--10	824,541	73
74	Depr Exp (Net Allowable) - Rel Party Alloc Sch. VIII		833	833				74
75	TOTALS	\$1,031,947	\$33,181	\$33,181	\$		\$911,904	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)			\$	4,925,685
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	133,953
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	133,953
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)			\$	3,548,013

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	\$139,357	\$3,247	\$130,771
87	Assets below IL Capital Threshold	504,972	34,661	414,332
88	Assets Disallowed by DHS Cap Review	1,144,060	23,870	992,827
89				
90				
91	TOTALS	\$1,788,389	\$61,778	\$1,537,930

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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 - Facility and fixed equipment 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	8,821	10	10	5
6								6
7	TOTAL				\$ 8,821			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 ☒ X NO Terms: *

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

15. Is Movable equipment rental included in building rental?

☒ X YES ☐ NO

16. Rental Amount for movable equipment: \$ 22,545 Description: Copier/Scanner Lease - 16,457 Medical Equipment 6,088

(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 12/01/2011

Ending 12/01/2021

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

Fiscal Year Ending Annual Rent

12. 06/30/2021 \$ Corp Alloc Amt

13. 06/30/2022 \$ Corp Alloc Amt

14. 06/30/2023 \$ Corp Alloc Amt

* 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	\$	920	\$ 49,421	\$	920	\$ 49,421	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		965	72,371		965	72,371	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		100	6,300		100	6,300	4
5	Physician Care	39.3	visits			7,833			7,833	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		147	9,745		147	9,745	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10a.3			29	985		29	985	12
13	Other (specify): <u>NOTE: Line 5 Physician Care is flat fee neurologist evaluations</u>									13
14	TOTAL			\$	2,161	\$ 146,655	\$	2,161	\$ 146,655	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	\$ 2,073,918	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,764)	1,495,844		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	225,496		6
7	Other Prepaid Expenses	10,662		7
8	Accounts Receivable (owners or related parties)	11,122,192		8
9	Other(specify): <u>Goodwill</u>	531,191		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 15,459,303	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	228,867		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$ 228,867	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,688,170	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,880	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	520,978		30
31	Accrued Taxes Payable (excluding real estate taxes)	(3,528)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	214,518		36
37	<u>Other Current Liabilities</u>	228,867		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,028,715	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Rounding</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,028,715	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 14,659,455	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,688,170	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,550,065	1
2	Restatements (describe):		2
3	Rounding	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,550,072	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,109,383	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)	\$ 5,109,383	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)	\$ 14,659,455	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

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	\$ 12,818,497	1
2	Discounts and Allowances for all Levels	10,415	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,828,912	3
	B. Ancillary Revenue		
4	Day Care	2,124,766	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,124,766	8
	C. Other Operating Revenue		
9	Payments for Education	824,115	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		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)	\$ 824,115	23
	D. Non-Operating Revenue		
24	Contributions	11,927	24
25	Interest and Other Investment Income***	132	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,059	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Refunds/Rebates</u>	2,685	28
28a	<u>Other: Miscellaneous</u>	7,808	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,493	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,800,345	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,199,408	31
32	Health Care	4,108,889	32
33	General Administration	2,442,038	33
	B. Capital Expense		
34	Ownership	645,235	34
	C. Ancillary Expense		
35	Special Cost Centers	1,758,240	35
36	Provider Participation Fee	537,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,690,962	40
41	Income before Income Taxes (line 30 minus line 40)**	5,109,383	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,109,383	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 12,647,010	44
45	Private Pay - Net Inpatient Revenue	103,180	45
46	Medicare - Net Inpatient Revenue	35,877	46
47	Other-(specify) <u>Hospice</u>	26,735	47
48	Other-(specify) <u>Bad Debt</u>	16,110	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,828,912	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 114,154	\$ 54.88	1
2	Assistant Director of Nursing	1,959	2,400	87,016	36.26	2
3	Registered Nurses	40,405	44,367	1,357,121	30.59	3
4	Licensed Practical Nurses	5,493	6,209	159,972	25.76	4
5	CNAs & Orderlies	91,229	101,712	1,554,440	15.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	481	601	11,382	18.94	9
10	Activity Assistants	17,264	18,540	209,137	11.28	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,017	2,241	65,073	29.04	13
14	Head Cook	13,359	14,152	212,366	15.01	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,204	10,245	206,268	20.13	17
18	Housekeepers					18
19	Laundry	2,031	2,125	28,362	13.35	19
20	Administrator	2,080	2,080	141,182	67.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,755	4,251	125,346	29.49	24
25	Vocational Instruction	18,851	21,769	493,484	22.67	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)	47,521	52,259	825,387	15.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	257,729	285,031	\$ 5,590,690 *	\$ 19.61	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	\$ 13,668	1.3	35
36	Medical Director	N/A	69,000	9.3	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	Note: Medical Director paid flat fee, not hourly				47
48					48
49	TOTAL (lines 35 - 48)	318	\$ 82,668		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

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	
Kym Halberstadt	Administrator	0	\$ 141,182	Workers' Compensation Insurance	\$	86,167	IDPH License Fee	\$	
				Unemployment Compensation Insurance		(54,507)	Advertising: Employee Recruitment	10,434	
				FICA Taxes		322,100	Health Care Worker Background Check		
				Employee Health Insurance		524,565	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	2,409	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	8,192	
				Retirement Plan		(6,152)	Permits & Licenses	1,362	
				Employee Physicals		150	Unallowable Lobbying	(1,885)	
				Group Allocation PG8		18,561	Bank Fees	(555)	
				Less PG5A Non-Allowable DT		(207,120)	Less PG5A Non-Allowable DT	(7,413)	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 683,764	TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 141,182	line 22, col.8)			line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							N/A		
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$				See PG 21.2 for Detail	3,025	
(Attach a copy of any management service agreement)							Less PG5 Non-Allowable Items	(711)	
C. Professional Services							Corporate/Group Travel Alloc - G&A	13,380	
Vendor/Payee	Type		Amount				Seminar Expense		
MRC dba Exceptional Living Centers	Management Services	\$	449,172						
Various (See attachment)	Legal Services		30,106				Entertainment Expense	()	
Various	Accounting Services		15,464				(agree to Sch. V,		
Grace Financial Services	Management Services		199,788				line 24, col. 8)		
ADP/Payor	Payroll Processing		23,535				TOTAL	\$ 15,694	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(For legal fee disclosure, see page 39 of instructions)			\$ 718,065						

*** Attach copy of IMRF notifications**

****See instructions.**

Schedule XIX Supplemental Schedule
Legal Fees Detail

Date	Description	Amount
7/31/2019	Matter # 266570.00001	385.00
7/31/2019	Steptoe & Johnson PLLC	(385.00)
7/31/2019	Group Invoices paid from ELC	130.82
7/31/2019	Account # 25042.00001	1,485.00
8/31/2019	Acct # 25042.00001	797.50
8/31/2019	Client/Matter: 2928856.000032	1,376.50
9/30/2019	MAtter # 266570.00001	70.00
9/30/2019	KC - legal fees accrual 09.19	508.77
9/30/2019	Group Invoices paid from ELC	68.13
9/30/2019	Acct # 25042.00001	2,145.00
10/31/2019	Group Invoices paid from ELC	60.11
10/31/2019	Client/Matter: 2928856.000002	508.77
10/31/2019	Acct # 25042.00001	1,897.50
10/31/2019	Matter# 266570.00001	420.00
10/31/2019	Matter# 266570.00001	245.10
10/31/2019	KC - legal fees accrual 09.19	(508.77)
11/30/2019	Group Invoices paid from ELC	33.93
11/30/2019	Account # 25042.00001	2,997.50
11/30/2019	Matter # 266570.00001	245.00
12/31/2019	Group Invoices paid from ELC	1,934.17
12/31/2019	Cruser, Mitchell, Novitz, Sanc	(1,017.50)
12/31/2019	Cruser, Mitchell, Novitz, Sanc	1,017.50
12/31/2019	Cruser, Mitchell, Novitz, Sanc	1,017.50
1/31/2020	Acct # 25043.00000	1,017.50
1/31/2020	Cruser, Mitchell, Novitz, Sanc	(1,017.50)
1/31/2020	Group Invoices paid from ELC	2,132.07
2/29/2020	Acct # 25042.00001	3,300.00
3/31/2020	Group Invoices paid from ELC	1,730.95
3/31/2020	kc - additional accrual 03.20	5,603.50
4/9/2020	Invoice: 032620: Fisher Phillips	5,603.50
4/29/2020	Invoice: SSCC03312020: Exceptional Living t	1,730.95
4/30/2020	Invoice: 8720680: Baker, Donelson, Bearman,	1,330.50
4/30/2020	Invoice: 8731600: Baker, Donelson, Bearman,	136.00
4/30/2020	kc - additional accrual 03.20	(5,603.50)
4/30/2020	Reverse JE 137 EHC Group Invoice	(1,730.95)
5/31/2020	Revenue Import	(2,997.50)
5/31/2020	RCL Revenue Import	2,997.50
5/31/2020	Reverse JE 305	(2,997.50)
5/31/2020	Invoice: 2928856.000032: Baker, Donelson, B	1,654.50
5/31/2020	Invoice: 510257: Cruser, Mitchell, Novitz, Sar	55.00
6/30/2020	Accrue Purchase Activity Report	1,728.50
		<u><u>30,106.05</u></u>

Schedule V Line 24 Detailed Schedule - Travel & Seminar In-State Detail

In-State Travel	Amount	Sch. V Line.Col
Regional Support, Regional Clinical Nurse, Clinical	442	24.3
Ferdinand Mendoza, Education -QMRP, QIDP, RSD Training Seminar	170	24.3
Ferdinand Mendoza, Education -QMRP, Intake Screening	120	24.3
Ferdinand Mendoza, Education -QMRP, Residential Director Core Training	198	24.3
Gale Kirkpatrick, Maintenance Director, Quarterly HSTP Meeting	100	24.3
Kylie Waters, CFO/Consultant, Consulting	101	24.3
Janie Williams, Day Training QMRP, Intake Screening	193 *	24.3
John Lawrence, Education - Teacher, Intake Screening	81	24.3
Kym Halberstadt, Administrator, Monthly Illinois ED Meeting	1,388	24.3
Raymund Mangantulao, Education - QMRP, ICPN Workshop	138	24.3
Wynell Eakle, Regional Director of Business Office, Administrative Review	24	24.3
Miscellaneous Travel, Other non-care related	70 *	24.3
Line 24 Column 4 Total	3,025	
Line 24 Column 7 Adjustment - Corporate/Home Office Allocated Costs	13,380	
Line 24 Column 6 Total	16,405	
Non-allowable Amounts above removed through Sch 5 Adjustments:		
Non-care related amounts noted above (Page 5A)	(263) *	
Allocation for non-care related education and day training (see Page 11.2 & Page 5A)	(448)	
Line 24 Column 8 Total	15,694	
	-	

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; \$5,157 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? 6.04 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 134,359 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. \$ 537,152
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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 35,877
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe, LLP
- (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.