

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road Champaign 61821
Number City Zip Code

County: Champaign

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

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1989

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: Chris Louder
Telephone Number: (615) 917-4020
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 7/1/2024 to 6/30/2025 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)
(Type or Print Name) Chris Louder
(Title) VP of Finance - Hutson Wood (Manager)

Paid Preparer

(Signed)
(Print Name and Title) Eric Neidig Partner
(Firm Name & Address) Bradley Associates 201 S. Capitol Ave. Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>44,895</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>44,895</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED	37,661				718			38,379	9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	37,661				718			38,379	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 85.49%

D. How many bed reserve days during this year were paid by the Department? 304 (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 8/15/1989

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/15/1989 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter certified beds.
number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	392,661	23,549	23,678	439,888		439,888	(131,631)	308,257			1
2	Food Purchase		238,912		238,912		238,912	(73,131)	165,781			2
3	Housekeeping	315,093	54,873	149	370,115		370,115	(125,994)	244,121			3
4	Laundry	190,009	32,406	613	223,028	0	223,028	0	223,028			4
5	Heat and Other Utilities			159,114	159,114		159,114	(62,631)	96,483			5
6	Maintenance	172,784	27,464	131,196	331,444		331,444	(112,830)	218,614			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	1,070,547	377,204	314,750	1,762,501	0	1,762,501	(506,217)	1,256,284			8
	B. Health Care and Programs											
9	Medical Director			50,500	50,500		50,500	0	50,500			9
10	Nursing and Medical Records	4,350,559	467,296	5,058	4,822,913		4,822,913	(17,967)	4,804,946			10
10a	Therapy	107,918	3,501	175,025	286,444		286,444	(143,222)	143,222			10a
11	Activities	233,457	3,027	1,855	238,339		238,339	0	238,339			11
12	Social Services	29,882	62	1,811	31,755		31,755	0	31,755			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	4,721,816	473,886	234,249	5,429,951	0	5,429,951	(161,189)	5,268,762			16
	C. General Administration											
17	Administrative	186,169	104		186,273		186,273	(45,660)	140,613			17
18	Directors Fees			116,976	116,976		116,976	(28,673)	88,303			18
19	Professional Services			1,100,819	1,100,819		1,100,819	(435,341)	665,478			19
20	Dues, Fees, Subscriptions & Promotions			52,472	52,472	(1,357)	51,115	(33,343)	17,772			20
21	Clerical & General Office Expenses	99,972	23,744	161,676	285,392	885	286,277	(115,998)	170,279			21
22	Employee Benefits & Payroll Taxes			1,552,517	1,552,517		1,552,517	(427,187)	1,125,330			22
23	Inservice Training & Education			23,307	23,307	472	23,779	(6,543)	17,236			23
24	Travel and Seminar			8,170	8,170		8,170	(3,701)	4,469			24
25	Other Admin. Staff Transportation			18,755	18,755		18,755	(6,385)	12,370			25
26	Insurance-Prop.Liab.Malpractice			292,988	292,988		292,988	(56,217)	236,771			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	286,141	23,848	3,327,680	3,637,669	0	3,637,669	(1,159,048)	2,478,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,078,504	874,938	3,876,679	10,830,121	0	10,830,121	(1,826,454)	9,003,667			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				0		0	559,449	559,449			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			540,050	540,050		540,050	151,495	691,545			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			565,761	565,761		565,761	(565,761)	0			34
35	Rent-Equipment & Vehicles			19,415	19,415		19,415	(6,609)	12,806			35
36	Other (specify):*				0		0	28,761	28,761			36
37	TOTAL Ownership			1,125,226	1,125,226	0	1,125,226	167,335	1,292,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		31,768	24,899	56,667		56,667	0	56,667			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			829,783	829,783		829,783	0	829,783			42
43	Other (specify):* EDU/DT	1,733,260	5,578	1,039	1,739,877		1,739,877	(1,739,876)	1			43
44	TOTAL Special Cost Centers	1,733,260	37,346	855,721	2,626,327	0	2,626,327	(1,739,876)	886,451			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,811,764	912,284	5,857,626	14,581,674	0	14,581,674	(3,398,995)	11,182,679			45

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

Swann Special Care Center

Schedule V - Line 23 Detailed Schedule

Purpose of Seminar	Name of Attendee	Title of Attendee	Expense Amount
1 Relias Annual - Regulation of HHS	All Employees	Various	18,047
2 Safe Food Handlers Corporation - Food Handler Training	Various	Various	510
3 Beth Schafer - CPR/AED Training	Various	Various	4,500
4 Nataly Hunt - Food Service Certification	Nataly Hunt	Dietary	160
5 Jefferson Acierto - Food Protection Manager Training	Jefferson Acierto	Dietary	90
Line 23 Column 4 Total			23,307
Allowable Amounts Reclassed on Schedule V Column 5 (see Page 4.2)			
5 IHCA Conference	John Lawrence	Teacher	472
Non-Allowable Amounts Above Removed through Schedule 5 Adjustments: Line 23 Column 7 Adjustments			
Allocation for Non-Care Related Education and Day Training (see Page 5A & 11.1)			(6,543)
Line 23 Column 7 Total			(6,543)
Line 23 Column 8 Total			17,236

Description	Increase/Decrease	Schedule V Line
1 Reclassification of Dues		
Dues, Fees, Subscriptions & Promotions	(601)	20
Clerical & General Office Expenses	129	21
Inservice Training & Education	472	23
2 Reclassification of Admin Software Expense		
Dues, Fees, Subscriptions & Promotions	(756)	20
Clerical & General Office Expenses	756	21

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	\$ (1,739,876)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(105)	1		4
5	Telephone, TV & Radio in Resident Rooms	(12,834)	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	(541)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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				18
19	Entertainment				19
20	Contributions				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	(23,456)	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	(1,637,921)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,414,733)		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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)	15,738	19,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 15,738		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,398,995)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (3,676)	20	1
2	Non-Allowable CoC Membership	(440)	20	2
3	Non-Care Portion of Travel	(2,005)	24	3
4	Miscellaneous Income	(184)	21	4
5	Medical Supplies Rebate (DSSI & Medline)	(15,304)	10	5
6	Food Rebate (GFS)	(2,396)	2	6
7	Interest Expense - Late Fees	(568)	32	7
8	Advertising	(2,829)	21	8
9	Flowers	(4,228)	21	9
10	Goodwill Amortization	(53,119)	21	10
11	Patient Replacements	(346)	21	11
12	Non-Allowable Depreciation Expense	(19,923)	30	12
13	Non-Allowable Day Trng EDU Alloc - Dietary	(131,526)	1	13
14	Non-Allowable Day Trng EDU Alloc - Food Purchases	(70,735)	2	14
15	Non-Allowable Day Trng EDU Alloc - Housekeeping	(125,994)	3	15
16	Non-Allowable Day Trng EDU Alloc - Utilities	(49,797)	5	16
17	Non-Allowable Day Trng EDU Alloc - Maintenance	(112,830)	6	17
18	Non-Allowable Day Trng EDU Alloc - Therapy	(143,222)	10a	18
19	Non-Allowable Day Trng EDU Alloc - Admin	(45,660)	17	19
20	Non-Allowable Day Trng EDU Alloc - Directors	(28,673)	18	20
21	Non-Allowable Day Trng EDU Alloc - Prof Svcs	(212,581)	19	21
22	Non-Allowable Day Trng EDU Alloc - Dues/Fees	(5,771)	20	22
23	Non-Allowable Day Trng EDU Alloc - Clerical	(55,292)	21	23
24	Non-Allowable Day Trng EDU Alloc - Benefits	(427,187)	22	24
25	Non-Allowable Day Trng EDU Alloc - Inservice Trainin	(6,543)	23	25
26	Non-Allowable Day Trng EDU Alloc - Travel/Seminar	(1,696)	24	26
27	Non-Allowable Day Trng EDU Alloc - Admin Staff Trai	(6,385)	25	27
28	Non-Allowable Day Trng EDU Alloc - Insurance	(99,739)	26	28
29	Non-Allowable Day Trng EDU Alloc - Equip/Vehicle R	(6,609)	35	29
30	Marketing Supplies	(2,663)	10	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	(1,637,921)		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Hoosier Care, Inc.	100	Walter Lawson Children's Home	Loves Park, IL	Champaign Facility Co	Champaign, IL	Property Co.
		Exceptional Care & Training Center	Sterling, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Exceptional Living of Brazil	Brazil, IN	HHSS Management	Nashville, TN	Management Co.
		Richland Bean-Blossom Healthcare	Ellettsville, IN			
		Vernon Health & Rehabilitation	Wabash, IN			
		Emerald Spring Hill	Nashville, TN			

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	Group Mgmt/Dir Fees	\$ 116,976	Hoosier Care Investments	100.00%	\$ 116,976	\$	1
2	V				Note: See Schedule VII Section C for description.				2
3	V	19	Management Fees	999,037	HHSS Management	100.00%	765,462	(233,575)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,116,013			\$ 882,438	\$ * (233,575)	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	34	Related Party Building/Equip. Rental	\$ 565,761	Champaign Facility Company, LLC	100.00%	\$	\$ (565,761)	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		579,372	579,372	21
22	V	32	Related Party Interest (Net)		Champaign Facility Company, LLC		145,217	145,217	22
23	V	32	Related Party Amortization of Debt Cost		Champaign Facility Company, LLC		7,387	7,387	23
24	V	26	Related Party Insurance		Champaign Facility Company, LLC		43,522	43,522	24
25	V	19	Related Party Accounting Fees		Champaign Facility Company, LLC		10,815	10,815	25
26	V	36	Related Party Mortgage Insurance		Champaign Facility Company, LLC		28,761	28,761	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			\$ 565,761			\$ 815,074	\$ * 249,313	39

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

Ownership Listing-1

ID# 0035485

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Names of trust beneficiaries must be listed.

Percentage

Downloaded from <http://ajph.org/> at University of California, San Francisco on June 11, 2015

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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30								30

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	Jim Ridenour	Board Member	Governance	0.00							2
3	Jo Anne Corbitt	Board Member	Governance	0.00							3
4	Douglass Smith	Board Member	Governance	0.00							4
5	Laura Hawken	Board Member	Governance	0.00							5
6	Stephen Wood Jr	Board Member	Governance	0.00							6
7	Chris Hodges	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 HCI affiliated										8
9	facilities, SSCC being one of many. Therefore, no Board Fees or compensation paid directly by SSCC to the Directors, but rather the fees paid by SSCC to HCI are										9
10	combined with similar fees paid by other facilities, for HCI to provided governance and managerial oversight, including payment by HCI to Board members of each legal										10
11	entity. Fees paid by other IL facilities are shown on Page 7.1 The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the										11
12	facility:							Admin Fees	116,976	18.3	12
13								TOTAL	\$ 116,976		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	94,440
Swann Special Care Center	116,976
Exceptional Care & Training Center	80,364

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										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	TOTALS					\$	\$		\$	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	LP Mortgage HUD Loan		X	Facility Purchase Financing	\$33,275.74	11/1/2012	\$ 8,377,500	\$ 5,636,764	11/1/2042	0.0254	\$ 152,063	1
2	Hoosier Care Investments	X		Facility Building Financing	\$69,135.60	5/12/2021	8,265,458	6,609,515	6/1/2042	0.0800	539,482	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$102,411.34		\$ 16,642,958	\$ 12,246,279			\$ 691,545	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)						\$ 16,642,958	\$ 12,246,279			\$ 691,545	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,761 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.)

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,263 B. General Construction Type: Exterior Block & Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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 (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Swann School Education Program, cost removal adjustments & allocation to remove associated costs shown on Sch V. See PG 11.1 for further explanation.
Swann Development Day Training Program, cost removal adjustments & allocation to remove associated costs shown on Sch V. See PG 11.1 for further explanation.

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X 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	\$ 558,290	1
2					2
3	TOTALS	89,603		\$ 558,290	3

Swann Special Care Center

Schedule X Supplemental Schedule

Item 14 - Allocation of Non-Long Term Care Costs

(E) Swann Special Care Center operates Education and Development Day Training programs in a shared building onsite but separate 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 to line 43 of Schedule V, "Other Costs Centers", and are removed via adjustment on Schedule VI, line 1.

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

Costs incurred which benefit multiple 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 port 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 allocated 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.

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		\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 2,351,255
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	0	10	0		2,751
10	FIRE DOORS		6/20/1991		3,675	0	10	0		3,675
11	SPRINKLER/EXIT DEVICES OD		1/30/1992		3,162	0	10	0		3,162
12	ROOFING		12/4/1992		3,900	0	10	0		3,900
13	SPRINKLER SYSTEM		3/30/1993		14,460	0	10	0		14,460
14	FIRE DOORS, CLOSETS, TILE		11/1/1993		5,225	0	10	0		5,225
15	RESURFACE PARKING LOT		11/1/1993		19,115	0	10	0		19,115
16	HOODS, FANS, ANSUL SYSTEM		3/14/1995		2,500	0	10	0		2,500
17	WORK FOR EXHAUST FAN & HO		4/6/1995		3,995	0	10	0		3,995
18	WALK-IN COOLER		10/24/1995		3,334	0	10	0		3,334
19	REPLACE UNDERGROUND FUEL		11/11/1998		9,223	0	20	0		9,223
20	REPLACE 2 ROOFTOP HVAC UN		12/7/1998		17,650	0	10	0		17,650
21	BALANCE-INSTALL ALARM SYS		6/29/2000		2,730	0	5	0		2,730
22	INSTALL CLINICAL SINK.		7/18/2000		3,030	0	5	0		3,030
23	INSTALL DOORS AT KENWOOD		7/18/2000		4,028	0	15	0		4,028
24	REPLACE GATE VALVE/INSTAL		9/8/2000		6,005	0	15	0		6,005
25	NEW FLOOR DRAINS IN SHOWE		1/24/2001		3,180	0	15	0		3,180
26	INSTALL SHOWER DRAINS		7/16/2001		10,500	0	20	0		10,500
27	REPLACE DOORS		1/2/2002		3,000	0	5	0		3,000
28	SECURITY SYSTEM		2/21/2002		3,165	0	5	0		3,165
29	INTERNET SET-UP-WIRING, C		2/21/2002		6,141	0	15	0		6,141
30	INSTALL TWO SINKS		5/13/2002		3,561	0	5	0		3,561
31	RE-SEAL AND RE-STRIPE PAR		7/1/2002		2,810	0	10	0		2,810
32	INSTALL A/C ROOFTOP UNIT		8/26/2002		8,237	0	15	0		8,237
33	CENTRAL HEAT/AIR ROOFTOP		1/22/2003		5,180	0	15	0		5,180
34	Rooftop unit installed; heat/air wing 3		7/31/2003		10,910	0	15	0		10,910
35	Install draining system in courtyard		2/2/2004		9,268	0	7	0		9,268
36	roofing project-Wing 1,2,4 (23318.33+431		6/8/2005		66,485	0	15	0		66,485

*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:

7/1/2024

Ending:

6/30/2025

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	4/27/2006	\$ 10,714	\$ 0	15	\$ 0	\$	\$ 10,714	37
38	Deposit for duro last roof	7/13/2006	10,000	0	15	0		10,000	38
39	Duro last roof - payment #2	7/13/2006	4,384	0	15	0		4,384	39
40	100 amp sub panel	9/25/2006	2,650	0	15	0		2,650	40
41	Re-tile shower room #10	9/27/2006	11,642	0	15	0		11,642	41
42	Parking lot/dumpster pad repaved	10/20/2006	8,073	0	10	0		8,073	42
43	Replace walls in dishwasher area	12/5/2006	7,477	0	15	0		7,477	43
44	Re-tile shower room #3	12/15/2006	11,642	0	15	0		11,642	44
45	Fence/dumpster enclosure	12/16/2006	2,750	0	10	0		2,750	45
46	Re-tile shower room #4	12/28/2006	11,642	0	15	0		11,642	46
47	Re-tile shower room #s 5,6,7	3/15/2007	12,746	0	15	0		12,746	47
48	Rpl motors on roof exhaust fans (7)	8/7/2007	2,667	0	10	0		2,667	48
49	Upgrade lighting system in education bld	8/21/2007	6,501	0	15	0		6,501	49
50	Re-tile team 6 bathroom	8/29/2007	7,561	0	15	0		7,561	50
51	Wire breakroom & outlets for nurses stat	12/4/2007	2,574	0	15	0		2,574	51
52	Replace 2 doors in laundry area	2/29/2008	4,187	0	15	0		4,187	52
53	Remodel conf room (cabinets, counter, c-	7/10/2008	2,536	0	10	0		2,536	53
54	Addnl outlets (4 ea.) in rooms 5,6,8,9,	12/4/2008	7,625	0	15	0		7,625	54
55	Compressor for a/c unit	9/11/2009	2,830	0	10	0		2,830	55
56	Induct air purifiers (8) and required el	12/14/2009	3,638	0	10	0		3,638	56
57	Outlets (24) in resident rooms	10/9/2010	12,618	841	15	841		12,338	57
58	Outlets in rooms 3b/1b/5a/6a/5b/6b	12/16/2010	8,280	552	15	552		8,004	58
59	Outlets in rooms 7a/7b/13/14/17/11b/12a/	1/24/2011	13,800	920	15	920		13,263	59
60	Compressor & blower wheel	6/28/2011	2,575	0	10	0		2,575	60
61	Sprinklers for ext eaves on west wing	9/20/2011	4,275	0	10	0		4,275	61
62	Tile floor & walls of bathrooms (3)	11/29/2011	19,854	1,324	15	1,324		17,979	62
63	Heat exchanger	12/12/2011	4,035	0	10	0		4,035	63
64	Network drops (32) for Paige II	12/13/2011	2,550	0	10	0		2,550	64
65	Heat exchanger	3/16/2012	6,570	0	10	0		6,570	65
66	Renovate shower rooms #2/14/15	4/23/2012	19,500	1,300	15	1,300		17,117	66
67	Weatherization project	7/1/2012	3,099	0	10	0		3,099	67
68	Flooring for shower room	10/18/2012	6,000	0	10	0		6,000	68
69	Exterior painting & waterproofing	10/26/2012	9,752	650	15	650		8,235	69
70	TOTAL (lines 4 thru 69)		\$ 3,075,967	\$ 61,862		\$ 61,862	\$ 0	\$ 2,828,354	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:

7/1/2024

Ending:

6/30/2025

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		\$ 3,075,967	\$ 61,862		\$ 61,862	\$	\$ 2,828,354	1
2	<u>Emergency generator</u>	2/28/2013	63,610	4,241	15	4,241		52,302	2
3	<u>IDPH Electrical Work(Project:Swann Gener</u>	5/1/2013	32,000	2,133	15	2,133		25,778	3
4	<u>New Flooring Installed</u>	5/1/2013	6,133	409	15	409		4,940	4
5	<u>New Flooring Installed - 3rd Shower</u>	5/13/2013	6,000	400	15	400		4,833	5
6	<u>IDPH Electrical Work(Project:Swann Gener</u>	6/25/2013	17,855	1,190	15	1,190		14,284	6
7	<u>Drain Tile Installation</u>	10/23/2013	11,897	0	10	0		11,897	7
8	<u>Security System for Front Door</u>	3/5/2014	3,547	0	10	0		3,547	8
9	<u>Mop Room Renovation</u>	4/14/2014	3,520	0	10	0		3,520	9
10	<u>Mop Room Renovation</u>	4/15/2014	4,636	0	10	0		4,636	10
11	<u>TheraPure Tub</u>	8/26/2014	12,038	201	10	201		12,038	11
12	<u>Whirlpool Room Flooring</u>	8/27/2014	4,300	72	10	72		4,300	12
13	<u>Team 8 Shower Room Flooring</u>	2/17/2015	7,600	507	10	507		7,600	13
14	<u>HVAC unit</u>	6/1/2016	5,755	576	10	576		5,179	14
15	<u>Tank removal</u>	7/1/2016	7,750	775	10	775		6,910	15
16	<u>HVAC</u>	7/8/2016	10,975	1,098	10	1,098		9,786	16
17	<u>Nurse Call System - 50% Down Pmt</u>	3/27/2017	20,500	2,050	10	2,050		16,913	17
18	<u>Blinds Installed</u>	5/26/2017	7,203	720	10	720		5,823	18
19	<u>Nurse Call System - final pmt</u>	6/29/2017	20,042	2,004	10	2,004		16,034	19
20	<u>Staff Assist Button System Installed</u>	7/11/2017	2,800	280	10	280		2,216	20
21	<u>Resurface Parking Lot Final Pmt</u>	8/31/2017	9,125	912	10	912		7,148	21
22	<u>Resurface Parking Lot 50%</u>	8/31/2017	8,610	861	10	861		6,745	22
23	<u>Break Room Remodel</u>	11/22/2017	11,325	1,133	10	1,133		8,588	23
24	<u>Chain Link Fence</u>	1/18/2018	2,550	255	10	255		1,891	24
25	<u>Chain Link Fence</u>	9/7/2018	3,390	339	10	339		2,288	25
26	<u>Fencing</u>	5/8/2020	38,925	3,892	10	3,892		19,787	26
27	<u>4 Ton Cooling Unit Replacement for Kitchen</u>	1/1/2021	10,605	530	10	530		2,342	27
28	<u>Mock-up Room 6B</u>	12/14/2021	19,856	993	10	993		3,475	28
29	<u>Wall Protection Rooms 114, 115 & 116</u>	12/20/2021	8,200	410	10	410		1,435	29
30	<u>Restroom Renovation Rooms E128, E130, E157 & E159</u>	1/27/2022	48,800	2,440	10	2,440		8,337	30
31	<u>Room Renovations</u>	5/1/2022	85,047	4,252	10	4,252		13,112	31
32	<u>Room Renovation</u>	6/1/2022	118,175	5,909	10	5,909		17,726	32
33	<u>Architect Fees for New Building</u>	6/1/2022	433,952	14,465	40	14,465		43,395	33
34	TOTAL (lines 1 thru 33)		\$ 4,122,688	\$ 114,909		\$ 114,909	\$ 0	\$ 3,177,159	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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 12B, Carried Forward		\$ 4,122,688	\$ 114,909		\$ 114,909	\$	\$ 3,177,159	1
2	School Building, Day Training Center, Dining Area, Laundry	6/1/2022	9,037,514	301,250	40	301,250		903,751	2
3	Room Renovations	7/31/2022	27,372	1,369	10	1,369		3,992	3
4	Room Renovations	8/30/2022	35,576	1,779	10	1,779		5,040	4
5	Room Renovation	10/1/2022	37,385	1,869	10	1,869		4,985	5
6	Room Renovation	11/1/2022	38,590	1,930	10	1,930		4,985	6
7	Room Renovation	12/1/2022	40,578	2,029	10	2,029		5,072	7
8	Room Renovation	1/25/2023	28,247	1,412	10	1,412		3,413	8
9	Resident Room Renovations, Dental & Doctor's Offices	3/3/2023	24,046	1,202	10	1,202		2,705	9
10	Room Renovation - Room 17, Partial Dr Office & Isolation Room	6/1/2023	36,904	1,845	10	1,845		3,690	10
11	Finish School Building, Day Training Center + Retainage	6/1/2022	244,735	12,237	40	12,237		36,710	11
12	Room Renovation - Isolation/Bath & Food Service Director's Office	8/28/2023	45,025	2,251	10	2,251		4,127	12
13	Office Door Painting & Exterior Kitchen Door Replacement	10/31/2023	6,407	320	10	320		534	13
14	Resident Room Reno	4/30/2024	50,186	2,509	10	2,509		2,928	14
15	Felmley Dickerson Co. Room Reno	6/30/2024	23,199	1,160	10	1,160		1,160	15
16	Felmley Dickerson Co. Room Reno Inv 23-033-2 Partial Pymt	8/26/2024	24,138	1,006	10	1,006		1,006	16
17	Resident Room Renovations	10/11/2024	21,965	732	10	732		732	17
18	Felmley Dickson Storage Room Reno	11/4/2024	9,999	292	10	292		292	18
19	Heat Exchanger/Motor Replacement	12/31/2024	8,067	202	5	202		202	19
20	Dave & Harry Locksmiths-New Locks for Facility	1/20/2025	5,533	115	10	115		115	20
21	Resident Room Renovations	12/10/2024	25,088	627	10	627		627	21
22	Resident Room Renovations	2/13/2025	21,161	353	10	353		353	22
23	Broeren Constrution: Room 4 Room Reno	3/11/2025	34,214	428	10	428		428	23
24	Room Renovation	4/22/2025	21,903	0	10	0		0	24
25	Demo and Install Finishes in Team Room 2	5/7/2025	22,353	0	10			0	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,992,873	\$ 451,826		\$ 451,826	\$ 0	\$ 4,164,006	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	\$600,578	\$96,060	\$96,060	\$0	5-7	\$323,558	71
72	Current Year Purchases	108,509	6,470	6,470	0	5	6,470	72
73	Fully Depreciated Assets	885,886	93	93	0	5-10	885,886	73
74					0			74
75	TOTALS	\$1,594,973	\$102,623	\$102,623	\$0		\$1,215,914	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2012 Chrysler Town & Country	2023	\$25,000	\$5,000	\$5,000	\$0	10	\$10,833	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$25,000	\$5,000	\$5,000	\$0		\$10,833	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$16,171,136	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$559,449	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$559,449	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,390,753	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Transportation Equip Not Allowed	\$149,386	\$2,233	\$145,040	86
87	Assets below IL Capital Threshold	478,424	6,192	470,288	87
88	Assets Disallowed by DHS Cap Review	1,137,034	11,499	1,056,505	88
89					89
90					90
91	TOTALS	\$1,764,844	\$19,924	\$1,671,833	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Facility and fixed equipment are 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. YESNO

		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: YESNO Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO

16. Rental Amount for movable equipment: \$ 19,415 Description: See PG 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year EndingAnnual Rent

12. /2026\$

13. /2027\$

14. /2028\$

* 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.

Swann Special Care Center
Moveable Equipment Rental Detail

Description	Amount	Schedule V Line
1 Copier Rental	13,170	35
2 Dehumidifier Rental	59	35
3 Space Heater Rental	381	35
4 Compacter Rental	981	35
5 Concentrator Rentals	4,505	35
6 Medline Pump Rental	320	35
	19,416	

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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

\$

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			(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	\$	1,764	\$ 101,375	\$	1,764	\$ 101,375	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		870	65,250		870	65,250	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	4662 hrs	107,917	120	8,400		4,782	116,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			15,900			15,900	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 107,917	2,754	\$ 190,925	\$	7,416	\$ 298,842	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$1,965,625	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	1,691,970		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	452,132		6
7	Other Prepaid Expenses	16,476		7
8	Accounts Receivable (owners or related parties)	10,682,431		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$14,808,634	\$0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			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	330,291		21
22	Other Long-Term Assets (specify) Other Prop.	(2,978)		22
23	Other(specify): Goodwill	371,834		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$699,147	\$0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$15,507,781	\$0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$160,410	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	312,147		29
30	Accrued Salaries Payable	711,496		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	44,063		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Trust	329,991		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$1,558,107	\$0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,297,369		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$6,297,369	\$0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$7,855,476	\$0	46
47	TOTAL EQUITY(page 18, line 24)	\$7,652,305	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$15,507,781	\$0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$8,501,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$8,501,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,399,664	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)	\$5,399,664	17
	B. Transfers (Itemize):		
18	Other Equity Withdrawals	(6,249,024)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$(6,249,024)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$7,652,305	24

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	\$ 15,445,234	1
2	Discounts and Allowances for all Levels	3,533	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,448,767	3
	B. Ancillary Revenue		
4	Day Care	3,101,209	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,101,209	8
	C. Other Operating Revenue		
9	Payments for Education	1,361,367	9
10	Other Government Grants	51,464	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	105	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)	\$ 1,412,936	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	541	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 541	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attachment PG19.1</u>	17,885	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,885	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,981,338	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,762,501	31
32	Health Care	5,429,951	32
33	General Administration	3,637,669	33
	B. Capital Expense		
34	Ownership	1,125,226	34
	C. Ancillary Expense		
35	Special Cost Centers	1,796,544	35
36	Provider Participation Fee	829,783	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,581,674	40
41	Income before Income Taxes (line 30 minus line 40)**	5,399,664	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,399,664	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 15,092,750.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	352,484.00	48
49	Medicare Part A		49
50	Other-(specify) <u>Bad Debt</u>	3,533.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,448,767	56

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	
	E. Other Revenue (specify):****		
28.1	Refunds/Rebates	17,701	28.1
28.2	Vendor Discounts	91	28.2
28.3	Other: Miscellaneous	33	28.3
28.4	Other: Miscellaneous	60	28.4
	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,885	

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	1,804	2,080	\$ 144,516	\$ 69.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,803	37,188	1,857,468	49.95	3
4	Licensed Practical Nurses	7,387	7,761	334,420	43.09	4
5	CNAs & Orderlies	74,069	78,651	1,913,315	24.33	5
6	CNA Trainees					6
7	Licensed Therapist	4,272	4,662	107,917	23.15	7
8	Rehab/Therapy Aides					8
9	Activity Director	859	989	24,230	24.50	9
10	Activity Assistants	11,091	11,984	209,227	17.46	10
11	Social Service Workers	1,114	1,243	29,882	24.04	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,160	76,935	35.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,415	14,585	315,726	21.65	15
16	Dishwashers					16
17	Maintenance Workers	5,026	5,377	172,784	32.13	17
18	Housekeepers	14,851	15,672	315,093	20.11	18
19	Laundry	8,961	9,523	190,009	19.95	19
20	Administrator	1,968	2,080	186,169	89.50	20
21	Assistant Administrator					21
22	Other Administrative	3,514	3,940	99,972	25.37	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,946	4,190	100,840	24.07	31
32	Other Health Care(specify)					32
33	Other(specify) DT/EDU	56,556	63,231	1,733,260	27.41	33
34	TOTAL (lines 1 - 33)	245,484	265,316	\$ 7,811,763 *	\$ 29.44	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	300	\$ 14,416	1.3	35
36	Medical Director	Monthly	50,500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Service	8,999	39.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	303	43.3	43
44	Activity Consultant	26	1,811	11.3	44
45	Social Service Consultant	26	1,811	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	\$ 77,840		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSwann Special Care Center# 0035485Report Period Beginning:7/1/2024Ending:6/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kym Halberstadt	Executive Director	0	\$ 186,169
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 186,169

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See PG 21.1	Legal Services	\$ 29,066
See PG 21.2	Accounting Services	17,347
HHSS Support Fees	Management Services	999,037
Various	Administrative Services	18,333
Navex	Incident Management	2,156
PayNW	Payroll Processing	34,880
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 1,100,819

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 92,746	
Unemployment Compensation Insurance	1,235	
FICA Taxes	576,356	
Employee Health Insurance	664,196	
Employee Meals	2,437	
Illinois Municipal Retirement Fund (IMRF)*		
401K Retirement Plan	215,136	
Employee Physicals	412	
Less PG5A Non-Allowable EDU/DT	(427,187)	
Rounding	(1)	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,125,330

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	3,000	
Health Care Worker Background Check (Indicate # of checks performed 2)	7,898	
Patient Background Checks		
Association Dues (total from pg 22, #4)	13,398	
Bank Fees	835	
Permits & Licenses	2,088	
Purch. Services / Pro. Fees	23,456	
Less PG5A Non-Allowable EDU/DT	(5,771)	
Less: Public Relations Expense	(	
PAC and Lobbying payments	(3,676)	
All non-allowable advertising	(23,456)	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,772

G. Schedule of Travel and Seminar**

Description	Amount	
Out-of-State Travel	\$ 510	
In-State Travel	2,127	
Meals	5,533	
Less PG5A Non-Allowable EDU/DT	(1,696)	
Less Non-Care Amounts	(2,005)	
Seminar Expense		
Entertainment Expense	(	
(agree to Sch. V, line 24, col. 8)		\$ 4,469

* Attach copy of IMRF notifications

**See instructions.

XIX. SUPPORT SCHEDULES
Legal Fees Detail

Date	Vendor	Description	Amount
7/31/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	July 2024 - FEMA Matters	65
8/6/2024	POLSINELLI PC	IL Medicaid Bed Hold Matter	1,305
9/30/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	NRAI & SOS	447
10/31/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	October 2024 - FEMA Matters	203
12/30/2024	Maatuka AI-Heeti Emkes LLC	Work on Nursing Contracts	1,860
1/1/2025	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	December 2024 - FEMA Matters	68
2/28/2025	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	February 2025 - FEMA Matters	119
3/27/2025	Great American Insurance Group	Case Settlement	25,000
			29,066

See Schedule VI for adjustment for non-allowable portion.

XIX. SUPPORT SCHEDULES

Accounting Fees Detail

Date	Vendor	Description	Amount
7/12/2024	CROWE LLP	First Installment for 990 preparation	\$ 350
7/31/2024	Bradley & Associates, PC	Progress Billings for Mcaid Cost Report	\$ 1,992
8/31/2024	Bradley & Associates, PC	Progress Billings for Mcaid Cost Report	\$ 2,000
9/17/2024	CROWE LLP	Progress billing for 6/30/24 audit	\$ 4,200
9/30/2024	Bradley & Associates, PC	Progress Billing for Preparation of the Education Report	\$ 757
10/1/2024	Bradley & Associates, PC	Final Billing for Mcaid Cost Report	\$ 708
10/15/2024	CROWE LLP	Progress billing for 6/30/24 audit	\$ 2,250
10/31/2024	Bradley & Associates, PC	Progress Billing for Preparation of the Education Report	\$ 500
11/15/2024	CROWE LLP	2023 tax compliance HW Inc. 990 review	\$ 245
12/31/2024	Bradley & Associates, PC	Education Cost Report Filing	\$ 225
2/12/2025	CROWE LLP	Progress billing for 2023 tax compliance services	\$ 1,085
6/3/2025	CROWE LLP	Audit services for HW Health and Housing for YE 06-30-25	\$ 2,300
6/16/2025	CROWE LLP	2023 tax compliance services	\$ 735
			<u>17,347</u>

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	6,677
Other, please specify AHCA, PCA, CARLE	3,045
	9,722 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	3,676
0	
Other, please specify AHCA, PCA, CARLE	
	3,676 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	10,353
0	0
Other, please specify AHCA, PCA, CARLE	3,045
	0
	13,398 Total
- (5)

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

\$ 153,945 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

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

\$ 829,783
This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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

No
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ No Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

Travel and Transportation

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

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

Yes \$ 0
- (13)

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

Firm Name: Crowe, LLP Yes
- (14)

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

Yes
- (15)

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.