

		FOR BHF USE					

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**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0048611</u></p> <p><b>Facility Name:</b> <u>Swansea Rehabilitation &amp; Health Care Center</u></p> <p><b>Address:</b> <u>1405 North Second Street</u> <u>Swansea</u> <u>62226</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>St. Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 233-6625</u> <b>Fax #</b> <u>(618) 233-5858</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1/4/2007</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:15%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> Fax # <u>( )</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Telephone) <u>( )</u> Fax # <u>( )</u>																																				

Facility Name & ID Number Swansea Rehabilitation & Health Care Center

# 0048611 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,854	1,095	1,576	21,525	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,854	1,095	1,576	21,525	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.74%

D. How many bed reserve days during this year were paid by the Department? None (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 1/4/2007

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/4/2007 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 94 and days of care provided 1,382

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center # 0048611 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

**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
	<b>A. General Services</b>										
1	Dietary	135,323	16,223		151,546		151,546	5,228	156,774		1
2	Food Purchase		132,963		132,963		132,963	(1,514)	131,449		2
3	Housekeeping	95,182	41,162		136,344		136,344	83	136,427		3
4	Laundry	38,172	7,313	136	45,621		45,621		45,621		4
5	Heat and Other Utilities			84,621	84,621		84,621	267	84,888		5
6	Maintenance	32,654	5,311	15,708	53,673		53,673	2,050	55,723		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	301,331	202,972	100,465	604,768		604,768	6,114	610,882		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,050,197	127,778	59,693	1,237,668		1,237,668	(232)	1,237,436		10
10a	Therapy			517,442	517,442		517,442		517,442		10a
11	Activities	45,531	68	898	46,497		46,497	(3,715)	42,782		11
12	Social Services	32,858	203		33,061		33,061		33,061		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	1,128,586	128,049	590,033	1,846,668		1,846,668	(3,947)	1,842,721		16
	<b>C. General Administration</b>										
17	Administrative			311,500	311,500		311,500	(221,000)	90,500		17
18	Directors Fees										18
19	Professional Services			2,254	2,254		2,254	58,093	60,347		19
20	Dues, Fees, Subscriptions & Promotions			1,518	1,518		1,518	3,478	4,996		20
21	Clerical & General Office Expenses	27,686	4,897	14,775	47,358		47,358	53,546	100,904		21
22	Employee Benefits & Payroll Taxes			162,261	162,261		162,261	23,504	185,765		22
23	Inservice Training & Education							131	131		23
24	Travel and Seminar			125	125		125	3	128		24
25	Other Admin. Staff Transportation			7,088	7,088		7,088	3,980	11,068		25
26	Insurance-Prop.Liab.Malpractice			28,890	28,890		28,890	998	29,888		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	27,686	4,897	528,411	560,994		560,994	(77,267)	483,727		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,457,603	335,918	1,218,909	3,012,430		3,012,430	(75,100)	2,937,330		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 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	
	<b>D. Ownership</b>											
30	Depreciation			93,451	93,451		93,451	(4,694)	88,757			30
31	Amortization of Pre-Op. & Org.							115	115			31
32	Interest			35,845	35,845		35,845	36,780	72,625			32
33	Real Estate Taxes			50,626	50,626		50,626	395	51,021			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,434	39,434		39,434	1,149	40,583			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			219,356	219,356		219,356	33,745	253,101			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,818		36,818		36,818		36,818			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,478	172,478		172,478		172,478			42
43	Other (specify):* <b>Miscellaneous</b>		137	123,356	123,493		123,493	(123,493)				43
44	<b>TOTAL Special Cost Centers</b>		36,955	295,834	332,789		332,789	(123,493)	209,296			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,457,603	372,873	1,734,099	3,564,575		3,564,575	(164,848)	3,399,727			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,563)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,630)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,103)	30		9
10	Interest and Other Investment Income	(2,129)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(127)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(31,564)	43		18
19	Entertainment				19
20	Contributions	(720)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,000)	43		24
25	Fund Raising, Advertising and Promotional	21	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,536)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (155,351)		\$	30

**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)	(9,497)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (9,497)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (164,848)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

Swansea Rehabilitation & Health Care Center

ID# 0048611

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Labs-Part A	\$ (3,022)	43	1
2	X-Rays-Part A	(787)	43	2
3	Disallowed Special Events	(320)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(96)	21	4
5	Offset Transportation Revenue	(3,715)	11	5
6	Resident Flowers	(344)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(5,852)	10	7
8	Offset Chamber of Commerce Dues	(400)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(14,536)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,228	\$ 5,228	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	49	49	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	83	83	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	267	267	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,050	2,050	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,618	3,618	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	202,300	Petersen Health Care Management, Inc.	100.00%	90,500	(111,800)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	15,823	15,823	12
13	V							13
14	Total		\$ 202,300			\$ 117,618	\$ * (84,682)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs &amp; Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 3,878	\$	3,878	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	53,642		53,642	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	22,529		22,529	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	131		131	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3		3	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3,980		3,980	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	998		998	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	12,687		12,687	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	115		115	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3,336		3,336	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	395		395	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,149		1,149	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	<b>Total</b>		\$			\$ 102,843	\$ *	102,843	39

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Care II, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Care II, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Care II, LLC	100.00%	0	
19	V	5 Utilities		Petersen Health Care II, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Care II, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	2,002	2,002
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0	
24	V	17 Administrative	109,200	Petersen Health Care II, LLC	100.00%	0	(109,200)
25	V	19 Professional Services		Petersen Health Care II, LLC	100.00%	42,270	42,270
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%	0	
27	V	21 Clerical and General Office		Petersen Health Care II, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	975	975
29	V	23 Inservice Training & Education		Petersen Health Care II, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Care II, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%	0	
33	V	30 Depreciation		Petersen Health Care II, LLC	100.00%	722	722
34	V	31 Amortization		Petersen Health Care II, LLC	100.00%	0	
35	V	32 Interest		Petersen Health Care II, LLC	100.00%	35,573	35,573
36	V	33 Real Estate Taxes		Petersen Health Care II, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	0	
39	Total		\$ 109,200			\$ 81,542	\$ * (27,658)

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

Facility Name &amp; ID Number

Swansea Rehabilitation &amp; Health Care Center

# 0048611

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## VII. RELATED PARTIES

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

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

Facility Name &amp; ID Number

Swansea Rehabilitation &amp; Health Care Center

# 0048611

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## VII. RELATED PARTIES

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

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

Facility Name &amp; ID Number

Bloomington Rehabilitation &amp; Health Care Center

# 0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## VII. RELATED PARTIES

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

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

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

# 0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Cent # 0048611 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center # 0048611 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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

Name of Related Organization Petersen Health Care Management, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

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

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	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	21,525	\$ 5,228	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	21,525	49	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	21,525	83	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	21,525	267	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	21,525	2,050	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	21,525	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	21,525	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	21,525	3,618	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	21,525	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	21,525	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	21,525	90,500	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	21,525	15,823	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	21,525	3,878	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	21,525	53,642	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	21,525	22,529	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	21,525	131	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	21,525	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	21,525	3,980	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	21,525	998	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	21,525	12,687	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	21,525	115	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	21,525	3,336	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	21,525	395	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	21,525	1,149	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 220,461	25

Facility Name & ID Number Swansea Rehabilitation & Health Care Center # 0048611 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Care II, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309)691-8113  
 Fax Number (309)691-8622

1	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	Dietary	Resident Days	135,903	5	\$	\$ 21,525	\$	1
2	2	Food	Resident Days	135,903	5		21,525		2
3	3	Housekeeping	Resident Days	135,903	5		21,525		3
4	4	Laundry	Resident Days	135,903	5		21,525		4
5	5	Utilities	Resident Days	135,903	5		21,525		5
6	6	Maintenance	Resident Days	135,903	5		21,525		6
7	7	Mgmt. Allocation of Benefits	Resident Days	135,903	5		21,525		7
8	10	Nursing and Medical Records	Resident Days	135,903	5	12,637	21,525	2,002	8
9	15	Mgmt. Allocation of Benefits	Resident Days	135,903	5		21,525		9
10	17	Administrative	Resident Days	135,903	5		21,525		10
11	19	Professional Services	Resident Days	135,903	5	266,883	21,525	42,270	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	135,903	5		21,525		12
13	21	Clerical and General Office	Resident Days	135,903	5		21,525		13
14	22	Employee Benefits & Payroll	Resident Days	135,903	5	6,156	21,525	975	14
15	23	Inservice Training & Education	Resident Days	135,903	5		21,525		15
16	24	Travel and Seminar	Resident Days	135,903	5		21,525		16
17	25	Other Admin. Staff Transport.	Resident Days	135,903	5		21,525		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	135,903	5		21,525		18
19	30	Depreciation	Resident Days	135,903	5	4,559	21,525	722	19
20	31	Amortization	Resident Days	135,903	5		21,525		20
21	32	Interest	Resident Days	135,903	5	224,601	21,525	35,573	21
22	33	Real Estate Taxes	Resident Days	135,903	5		21,525		22
23	34	Rent-Facility and Grounds	Resident Days	135,903	5		21,525		23
24	35	Rent-Equipment & Vehicles	Resident Days	135,903	5		21,525		24
25	TOTALS					\$ 514,836	\$	\$ 81,542	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Huntington Bank		X	Mortgage	Varies	2/1/17	\$ 749,900	\$ 554,070	1/31/22	Varies	\$ 35,845	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 749,900	\$ 554,070			\$ 35,845	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(2,129)	10						
11									Home Office Allocation-PHCM		3,336	11						
12									Home Office Allocation-PHC II		35,573	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 36,780	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 749,900	\$ 554,070			\$ 72,625	15						

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.		\$	<b>51,636</b>	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).		\$	<b>(51,636)</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>102,262</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>Home Office Allocation</b>		\$	<b>395</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>51,021</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	<u>40,502</u>	8	
	2014	<u>41,762</u>	9	
	2015	<u>45,949</u>	10	
	2016	<u>50,126</u>	11	
	2017	<u>50,374</u>	12	
<b>Accrual based on prior year tax bill.</b>				

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Swansea Rehabilitation & Health Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0048611

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>08-16.0-409-014</u>	<u>Long-Term Care Facility</u>	\$ <u>50,373.90</u>	\$ <u>50,373.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>50,373.90</u></u>	\$ <u><u>50,373.90</u></u>

**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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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.**

Facility Name & ID Number Swansea Rehabilitation & Health Care Center

# 0048611

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO

If so, please complete the following:

1. Total Amount Incurred: 799,059 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 115 4. Dates Incurred: 2013-2014

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 100,800, 2006, \$ 70,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 100,800, (blank), \$ 70,000, 3.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	94		2006	1975	\$ 1,735,000	\$	30	\$ 57,833	\$ 57,833	\$ 722,913	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Sidewalk		2006		500		10			500	9
10	Landscaping		2007		1,685		15	112	112	1,120	10
11	Carpeting		2007		1,637		10			1,637	11
12	Awning		2007		815		10			815	12
13	Blinds		2007		1,883		10			1,883	13
14	Signage		2007		2,770		10			2,770	14
15	Roof Top Air Conditioners		2007		16,613		10			16,613	15
16	Landscaping		2008		3,385		15	226	226	2,373	16
17	Water Heater		2008		8,724		5			8,724	17
18	Cable Equipment Installation		2009		7,264		7	517	517	7,264	18
19	Water Heater		2010		7,490		10	750	750	6,375	19
20	Dining Room Floor		2010		8,638		15			8,638	20
21	Water Heater		2011		3,500		7	250	250	3,500	21
22	Water Line Repair		2011		4,822		7	350	350	4,822	22
23	Garage		2011		2,770		15	184	184	1,380	23
24	Smoke Detection System		2011		7,947		10	404	404	7,947	24
25	Water Heater		2012		3,637		7	520	520	3,380	25
26	Sprinkler System		2012		119,898		25	4,796	4,796	31,174	26
27	Water Heater		2014		4,021		7	574	574	2,583	27
28	Nurse Call Replacement		2014		9,976		7	1,425	1,425	6,413	28
29	Sewer Line Replacement		2014		13,300		15	887	887	3,992	29
30	Air Conditioner-Kitchen		2016		7,442		15	496	496	1,240	30
31	Air Conditioner-Hallway 100		2016		7,280		15	486	486	1,215	31
32	HVAC-Hallway 200		2017		9,466		15	632	632	948	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64	Land Improvements Booked		1,038			(1,038)		64
65	Building Booked		69,400			(69,400)		65
66	Building Improvement Booked		17,792			(17,792)		66
67								67
68	2018-Home Office Allocation-Building Improvements	10,125			243	243		68
69	2018-Home Office Allocation-Land Improvements	1,016			64	64		69
70	TOTAL (lines 4 thru 69)	\$ 2,001,604	\$ 88,230		\$ 70,749	\$ (17,481)	\$ 850,219	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 43,675	\$ 4,606	\$ 4,367	\$ (239)	5-10 yrs.	\$ 23,962	71
72	Current Year Purchases	7,548	615	539	(76)	7 yrs.	539	72
73	Fully Depreciated Assets	381,759					381,759	73
74	Home Office Allocation			13,102	13,102			74
75	TOTALS	\$ 432,982	\$ 5,221	\$ 18,008	\$ 12,787		\$ 406,260	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Ford E-150	2007	\$ 28,977	\$	\$	\$		\$ 28,977	76
77										77
78										78
79										79
80	TOTALS			\$ 28,977	\$	\$	\$		\$ 28,977	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,533,563	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,757	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,694)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,285,456	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		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 40,583 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2019 \$ \_\_\_\_\_

13. \_\_\_\_\_/2020 \$ \_\_\_\_\_

14. \_\_\_\_\_/2021 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



**Swansea Rehabilitation & Health Care Center**

**0048611**

**Period Beginning** 1/1/2018

**Period End** 12/31/2018

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 33,227
Dishwasher	701
Floor Cleaner	332
Copier	5,174
Home Office Allocation	1,149
	<u>40,583</u>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	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	\$	16,631	\$ 249,463	\$	16,631	\$ 249,463	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,412	51,183		3,412	51,183	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		14,422	216,334		14,422	216,334	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				36,818		36,818	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)	hrs		31	462		31	462	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	34,496	\$ 517,442	\$ 36,818	34,496	\$ 554,260	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2018**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,307,624)	\$ (1,307,624)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>318,405</u> )	4,003,729	4,003,729	3
4	Supply Inventory (priced at <u>Cost</u> )	9,014	9,014	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,957	17,957	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	105,989	105,989	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,829,065	\$ 2,829,065	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,570	70,000	13
14	Buildings, at Historical Cost	1,735,000	1,745,125	14
15	Leasehold Improvements, at Historical Cost	277,629	256,479	15
16	Equipment, at Historical Cost	461,959	461,959	16
17	Accumulated Depreciation (book methods)	(1,452,070)	(1,285,456)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,098,088	\$ 1,248,107	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,927,153	\$ 4,077,172	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 961,163	\$ 961,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,078	69,078	30
31	Accrued Taxes Payable (excluding real estate taxes)	368,825	368,825	31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,262	102,262	32
33	Accrued Interest Payable	3,109	3,109	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	2,663	2,663	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,507,100	\$ 1,507,100	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	554,070	554,070	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 554,070	\$ 554,070	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,061,170	\$ 2,061,170	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,865,983	\$ 2,016,002	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,927,153	\$ 4,077,172	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,387,066</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Reports Were Filed</b>	<b>(7,244)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,379,822</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>486,161</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>486,161</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,865,983</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Swansea Rehabilitation &amp; Health Care Center

# 0048611

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,411,760	1
2	Discounts and Allowances for all Levels	(342,320)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,069,440	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	887,984	6
7	Oxygen	9,006	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 896,990	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,563	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,077	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,945	20
21	Other Medical Services	8,912	21
22	Laundry	17	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 72,514	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,129	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,129	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	3,715	28
28a	<u>Miscellaneous Revenue</u>	5,948	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,663	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,050,736	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	604,768	31
32	Health Care	1,846,668	32
33	General Administration	560,994	33
<b>B. Capital Expense</b>			
34	Ownership	219,356	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	160,311	35
36	Provider Participation Fee	172,478	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,564,575	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	486,161	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 486,161	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,752,377	44
45	Private Pay - Net Inpatient Revenue	136,111	45
46	Medicare - Net Inpatient Revenue	147,702	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	33,250	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,069,440	49

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

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

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

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

Facility Name & ID Number **Swansea Rehabilitation & Health Care Center**

# **0048611**

Report Period Beginning: **1/1/2018**

Ending:

**12/31/2018**

**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	1,718	1,718	\$ 53,744	\$ 31.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,157	3,217	85,349	26.53	3
4	Licensed Practical Nurses	10,194	10,511	265,867	25.29	4
5	CNAs & Orderlies	44,505	45,078	555,377	12.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,992	2,049	29,496	14.40	8
9	Activity Director	1,945	2,073	24,799	11.96	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	32,858	15.80	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,589	13.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,955	11,508	106,734	9.27	15
16	Dishwashers					16
17	Maintenance Workers	1,988	2,074	32,654	15.74	17
18	Housekeepers	10,953	11,168	95,182	8.52	18
19	Laundry	3,472	3,523	38,172	10.84	19
20	Administrator	2,080	2,080	90,500	43.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,005	2,068	27,686	13.39	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	744	744	18,610	25.01	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	2,762	2,813	62,486	22.21	33
34	TOTAL (lines 1 - 33)	102,630	104,784	\$ 1,548,103 *	\$ 14.77	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 12,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 5,831	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,831		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	200 \$ 8,828	L10, C3	50
51	Licensed Practical Nurses	1,022 44,300	L10, C3	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	1,222 \$ 53,128		53

Swansea Rehabilitation & Health Care Center  
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Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,167	1,167	41,754	35.78
Transportation	1,595	1,646	20,732	12.60
<b>TOTAL</b>	<b>2,762</b>	<b>2,813</b>	<b>62,486</b>	



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jifi Jacob	Administrator	0	\$ 90,500	Workers' Compensation Insurance	\$ 24,846	IDPH License Fee	\$	
				Unemployment Compensation Insurance	21,657	Advertising: Employee Recruitment		
				FICA Taxes	111,437	Health Care Worker Background Check		
				Employee Health Insurance	1,752	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	(110)	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	918	
				Employee Relations	2,569	Miscellaneous Dues & Subscriptions	710	
				Home Office Allocation	23,504	Home Office Allocation	3,878	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,500	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,996		
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
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 311,500				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 311,500				Seminar Expense	125
C. Professional Services				TOTAL			Home Office Allocation	
Vendor/Payee	Type		Amount				3	
Charter Communications	Computer Services		\$ 1,200				Entertainment Expense ( )	
Ability Network	Computer Services		1,073				(agree to Sch. V, line 24, col. 8)	
Sorling Northrup	Reimb. For Copying		(19)				TOTAL	
							\$ 128	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,254					

\* Attach copy of IMRF notifications

\*\*See instructions.

**Swansea Rehabilitation & Health Care Center**

0048611

Period Beginning

1/1/2018

Period End

12/31/2018

## Schedule 21A

**XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		2,254
<b>Home Office Allocation</b>		
Duane Morris	Legal	2163
Sedgwick CMS	Legal	191
SB2	Legal	534
Miscellaneous	Legal	159
Christoper P. Ryan	Legal	169
Saul Ewing Arnstein & Lehr	Legal	757
Healthcare Resources International	Legal	113
Winston & Strawn	Legal	1823
Lexis Nexis	Legal	8
Pretzel & Stouffer	Legal	27
Huntington Bank	Legal	6248
Baker Tilly Virchow Krause	Legal	693
Christoper P. Ryan	Legal	554
CliftonLarsonAllen	Accounting	1106
Ginoli & Co.	Accounting	392
Duane Morris	Accounting	64
Getzler Henrich & Associates	Accounting	850
Kemper Consulting	Accounting	64
Baker Tilly Virchow Krause	Accounting	447
Ginoli & Co.	Accounting	1993
Miscellaneous	Computer Services	101
Change Healthcare	Computer Services	4
TR Professional	Computer Services	11
Matrix Care	Computer Services	1242
Ability Network	Computer Services	1967
Stratus Networks	Computer Services	481
Kemper Technology	Computer Services	552
AT&T	Computer Services	6
Ungerboeck Software	Computer Services	397
CIAN	Computer Services	173
Comcast	Computer Services	43
CCH	Computer Services	16
Charter Communications	Computer Services	29
Allscripts	Computer Services	559
ATS	Computer Services	260
Citrix Systems	Computer Services	91
Optimizer	Other Prof Fees	50
Sedgwick CLMS	Other Prof Fees	175
David Budde	Other Prof Fees	50
Sargent Consulting	Other Prof Fees	138
Alix Partners	Other Prof Fees	522
Getzler Henrich & Associates	Other Prof Fees	71
Sargent Consulting	Other Prof Fees	22583
Alix Partners	Other Prof Fees	10217
Total (agree to Schedule V, line 19, column 8)		<u>60,347</u>

**Swansea Rehabilitation & Health Care Center  
0048611**

**Period Beginning**      1/1/2018  
**Period End**            12/31/2018

**Schedule 21B**

**25. Administrative and Staff Transportation**

Gas	\$	3,790
Auto Repairs		2,998
Travel-Mileage		300
Home Office Allocation		<u>3,980</u>
		<u><u>11,068</u></u>

**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-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,870 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 172,478  
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. \$ 1,563
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,715
  - c. What percent of all travel expense relates to transportation of nurses and patients? 100
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees