

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0056374</u></p> <p><b>Facility Name:</b> <u>Swansea Rehab Hlth Care Ctr</u></p> <p><b>Address:</b> <u>1405 North Second St</u> <u>Swansea</u> <u>62226</u> Number City Zip Code</p> <p><b>County:</b> <u>St Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 233-6625</u> Fax # <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 border="0"> <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> Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</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>1/1/2020</u> to <u>12/31/2020</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"> <tr> <td data-bbox="1473 755 1666 950" rowspan="2"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td data-bbox="1473 950 1666 1242" rowspan="4"><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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Mark 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>																																				
	<p><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>																																				

Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds** 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	16,012	213	1,432	17,657	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,012	213	1,432	17,657	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 51.46%

**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 1,222

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Swansea Rehab Hlth Care Ctr # 0056374 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	129,734	19,813	3,607	153,154		153,154	4,687	157,841		1
2	Food Purchase		127,901		127,901		127,901	(1,014)	126,887		2
3	Housekeeping	94,763	39,583		134,346		134,346	91	134,437		3
4	Laundry	46,739	6,284		53,023		53,023		53,023		4
5	Heat and Other Utilities			80,367	80,367		80,367	320	80,687		5
6	Maintenance	34,493	5,745	20,472	60,710		60,710	2,815	63,525		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>305,729</b>	<b>199,326</b>	<b>104,446</b>	<b>609,501</b>		<b>609,501</b>	<b>6,899</b>	<b>616,400</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	806,314	97,282	754,541	1,658,137		1,658,137	2,653	1,660,790		10
10a	Therapy		185	271,553	271,738		271,738		271,738		10a
11	Activities	24,728	405		25,133		25,133	285	25,418		11
12	Social Services	35,436	7		35,443		35,443		35,443		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>866,478</b>	<b>97,879</b>	<b>1,044,094</b>	<b>2,008,451</b>		<b>2,008,451</b>	<b>2,938</b>	<b>2,011,389</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	90,504		173,400	263,904		263,904	(147,333)	116,571		17
18	Directors Fees										18
19	Professional Services			174,339	174,339		174,339	73,472	247,811		19
20	Dues, Fees, Subscriptions & Promotions			3,914	3,914		3,914	2,400	6,314		20
21	Clerical & General Office Expenses	8,788	5,055	11,809	25,652		25,652	29,016	54,668		21
22	Employee Benefits & Payroll Taxes			157,201	157,201		157,201	8,127	165,328		22
23	Inservice Training & Education							48	48		23
24	Travel and Seminar			250	250		250	15	265		24
25	Other Admin. Staff Transportation			3,353	3,353		3,353	3,358	6,711		25
26	Insurance-Prop.Liab.Malpractice			44,825	44,825		44,825	512	45,337		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>99,292</b>	<b>5,055</b>	<b>569,091</b>	<b>673,438</b>		<b>673,438</b>	<b>(30,385)</b>	<b>643,053</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,271,499</b>	<b>302,260</b>	<b>1,717,631</b>	<b>3,291,390</b>		<b>3,291,390</b>	<b>(20,548)</b>	<b>3,270,842</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Swansea Rehab Hlth Care Ctr

#0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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							79,031	79,031			30
31	Amortization of Pre-Op. & Org.							58,846	58,846			31
32	Interest			4,976	4,976		4,976	239,630	244,606			32
33	Real Estate Taxes			51,822	51,822		51,822	185	52,007			33
34	Rent-Facility & Grounds			175,804	175,804		175,804	(175,804)				34
35	Rent-Equipment & Vehicles			32,331	32,331		32,331	82,518	114,849			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			264,933	264,933		264,933	284,406	549,339			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,948		36,948		36,948		36,948			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,254	150,254		150,254		150,254			42
43	Other (specify):*			167,288	167,288		167,288	(167,288)				43
44	<b>TOTAL Special Cost Centers</b>		36,948	317,542	354,490		354,490	(167,288)	187,202			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,271,499	339,208	2,300,106	3,910,813		3,910,813	96,570	4,007,383			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	(1,014)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,187)	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	(18,390)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	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	(18,860)	43		18
19	Entertainment				19
20	Contributions	(621)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(162,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,000)	43		24
25	Fund Raising, Advertising and Promotional	(297)	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	(18,451)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (351,412)		\$	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)	447,982	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 447,982		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 96,570		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 Rehab Hlth Care Ctr

ID# 0056374

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (12,707)	43	1
2	X-Rays-Part A	(3,402)	43	2
3	Disallowed Special Events	286	43	3
4	Offset Miscellaneous Office Supplies Revenue	(47)	21	4
5	Offset Transportation Revenue	285	11	5
6	Resident Flowers	(409)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(2,457)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(18,451)		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%	\$ 4,687	\$ 4,687	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	91	91	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	320	320	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,815	2,815	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%	4,392	4,392	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	173,400	Petersen Health Care Management, Inc.	100.00%	26,067	(147,333)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	15,397	15,397	12
13	V							13
14	Total		\$ 173,400			\$ 53,769	\$ * (119,631)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,400	\$ 2,400
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	29,063	29,063
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,978	7,978
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	48	48
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,358	3,358
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	512	512
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	4,745	4,745
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0	
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	231	231
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	185	185
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,702	1,702
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$			\$ 50,237	\$ * 50,237

\* 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%	\$	\$	15
16	V	2 Food		Petersen Health Care II, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Care II, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Care II, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Care II, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Care II, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	718	718	22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			23
24	V	17 Administrative		Petersen Health Care II, LLC	100.00%			24
25	V	19 Professional Services		Petersen Health Care II, LLC	100.00%	220,575	220,575	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%			26
27	V	21 Clerical and General Office		Petersen Health Care II, LLC	100.00%			27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	149	149	28
29	V	23 Inservice Training & Education		Petersen Health Care II, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Care II, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%			32
33	V	30 Depreciation		Petersen Health Care II, LLC	100.00%	329	329	33
34	V	31 Amortization		Petersen Health Care II, LLC	100.00%			34
35	V	32 Interest		Petersen Health Care II, LLC	100.00%	5,096	5,096	35
36	V	33 Real Estate Taxes		Petersen Health Care II, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	80,816	80,816	38
39	Total		\$			\$ 307,683	\$ * 307,683	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	6 Maintenance	\$	Swansea Land, LLC	100.00%	\$	\$	15
16	V	19 Professional Services	\$	Swansea Land, LLC	100.00%			16
17	V	21 Equipment		Swansea Land, LLC	100.00%			17
18	V	26 Insurance-Property		Swansea Land, LLC	100.00%			18
19	V	26 Insurance-Mortgage Insurance		Swansea Land, LLC	100.00%			19
20	V	30 Depreciation		Swansea Land, LLC	100.00%	92,347	92,347	20
21	V	31 Amortization		Swansea Land, LLC	100.00%	58,846	58,846	21
22	V	32 Interest		Swansea Land, LLC	100.00%	234,304	234,304	22
23	V	33 Real Estate Taxes		Swansea Land, LLC	100.00%			23
24	V	34 Rent-Income and Grounds	175,804	Swansea Land, LLC	100.00%		(175,804)	24
25	V							25
26	V							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		\$ 175,804			\$ 385,497	\$ * 209,693	39

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

Facility Name &amp; ID Number

Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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 Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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

Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## 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

Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Swansea Rehab Hlth Care Ctr # 0056374 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	1,286,694	75	\$ 341,556	\$ 398,718	17,657	\$ 4,687	1
2	2	Food	Resident Days	1,286,694	75	0	0	17,657	0	2
3	3	Housekeeping	Resident Days	1,286,694	75	6,605	3,056	17,657	91	3
4	5	Utilities	Resident Days	1,286,694	75	23,319	0	17,657	320	4
5	6	Maintenance	Resident Days	1,286,694	75	205,135	187,746	17,657	2,815	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	17,657	0	6
7	9	Medical Director	Resident Days	1,286,694	75	0	0	17,657	0	7
8	10	Nursing and Medical Records	Resident Days	1,286,694	75	320,054	736,064	17,657	4,392	8
9	10A	Therapy	Resident Days	1,286,694	75	0	0	17,657	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	17,657	0	10
11	17	Administrative	Resident Days	1,286,694	75	1,899,564	7,673,667	17,657	26,067	11
12	19	Professional Services	Resident Days	1,286,694	75	1,122,027	0	17,657	15,397	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,286,694	75	174,864	0	17,657	2,400	13
14	21	Clerical and General Office	Resident Days	1,286,694	75	2,117,879	2,195,755	17,657	29,063	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,286,694	75	581,392	0	17,657	7,978	15
16	23	Inservice Training & Education	Resident Days	1,286,694	75	3,515	0	17,657	48	16
17	24	Travel and Seminar	Resident Days	1,286,694	75	1,093	0	17,657	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,286,694	75	244,707	0	17,657	3,358	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,286,694	75	37,296	0	17,657	512	19
20	30	Depreciation	Resident Days	1,286,694	75	345,756	0	17,657	4,745	20
21	31	Amortization	Resident Days	1,286,694	75	0	0	17,657	0	21
22	32	Interest	Resident Days	1,286,694	75	16,848	0	17,657	231	22
23	33	Real Estate Taxes	Resident Days	1,286,694	75	13,448	0	17,657	185	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,286,694	75	124,022	0	17,657	1,702	24
25	TOTALS					\$ 7,579,080	\$ 11,195,006		\$ 104,006	25



Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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	92,563	5	\$	\$	11,162	\$	1
2	2	Food	Resident Days	92,563	5			11,162		2
3	3	Housekeeping	Resident Days	92,563	5			11,162		3
4	4	Laundry	Resident Days	92,563	5			11,162		4
5	5	Utilities	Resident Days	92,563	5			11,162		5
6	6	Maintenance	Resident Days	92,563	5			11,162		6
7	7	Mgmt. Allocation of Benefits	Resident Days	92,563	5			11,162		7
8	10	Nursing and Medical Records	Resident Days	92,563	5	5,954		11,162	718	8
9	15	Mgmt. Allocation of Benefits	Resident Days	92,563	5			11,162		9
10	17	Administrative	Resident Days	92,563	5			11,162		10
11	19	Professional Services	Resident Days	92,563	5	1,829,164		11,162	220,575	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	92,563	5			11,162		12
13	21	Clerical and General Office	Resident Days	92,563	5			11,162		13
14	22	Employee Benefits & Payroll	Resident Days	92,563	5	1,233		11,162	149	14
15	23	Inservice Training & Education	Resident Days	92,563	5			11,162		15
16	24	Travel and Seminar	Resident Days	92,563	5			11,162		16
17	25	Other Admin. Staff Transport.	Resident Days	92,563	5			11,162		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	92,563	5			11,162		18
19	30	Depreciation	Resident Days	92,563	5	2,726		11,162	329	19
20	31	Amortization	Resident Days	92,563	5			11,162		20
21	32	Interest	Resident Days	92,563	5	42,259		11,162	5,096	21
22	33	Real Estate Taxes	Resident Days	92,563	5			11,162		22
23	34	Rent-Facility and Grounds	Resident Days	92,563	5			11,162		23
24	35	Rent-Equipment & Vehicles	Resident Days	92,563	5	670,184		11,162	80,816	24
25	TOTALS					\$ 2,551,520	\$		\$ 307,683	25

Facility Name & ID Number

Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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	\$ Paid			\$ 4,976	1						
2	Sector		X	Mortgage	Varies	4/1/20	3,133,846	3,133,846	3/31/23	Varies	234,304	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 3,883,746	\$ 3,133,846			\$ 239,280	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(1)	10						
11									Home Office Allocation-PHCM		231	11						
12									Home Office Allocation-PHC II		5,096	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 5,326	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,883,746	\$ 3,133,846			\$ 244,606	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 2019 report.		\$	<b>52,518</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.)		\$	<b>51,396</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,122)</b>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>52,944</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>185</b>	
<b>TOTAL REFUND</b> \$ _____ <b>For</b> _____ <b>Tax Year.</b> <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>52,007</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	<b>45,949</b>	8
	2016	<b>50,126</b>	9
	2017	<b>50,374</b>	10
	2018	<b>51,427</b>	11
	2019	<b>51,396</b>	12

**Accrual based on prior year tax bill.**

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

**NOTES:**

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

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME 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 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-16.0-409-014</u>	<u>Long-Term Care Facility</u>	\$ <u>51,395.76</u>	\$ <u>51,395.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>51,395.76</u></u>	\$ <u><u>51,395.76</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   X   NO

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

**C. Tax Bills**

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

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

Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

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? [ ] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: 156,921 2. Number of Years Over Which it is Being Amortized: 3
3. Current Period Amortization: 58,846 4. Dates Incurred: 2020

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	\$ 838,579	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	1,344	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	2,825	16
17	Water Heater	2008		8,724		5			8,724	17
18	Cable Equipment Installation	2009		7,264		7			7,264	18
19	Water Heater	2010		7,490		10	365	365	7,490	19
20	Dining Room Floor	2010		8,638		15			8,638	20
21	Water Heater	2011		3,500		7			3,500	21
22	Water Line Repair	2011		4,822		7			4,822	22
23	Garage	2011		2,770		15	184	184	1,748	23
24	Smoke Detection System	2011		7,947		10			7,947	24
25	Water Heater	2012		3,637		7			3,637	25
26	Sprinkler System	2012		119,898		25	4,796	4,796	40,766	26
27	Water Heater	2014		4,021		7	574	574	3,731	27
28	Nurse Call Replacement	2014		9,976		7	1,425	1,425	9,263	28
29	Sewer Line Replacement	2014		13,300		15	887	887	5,766	29
30	Air Conditioner-Kitchen	2016		7,442		15	496	496	2,232	30
31	Air Conditioner-Hallway 100	2016		7,280		15	486	486	2,187	31
32	HVAC-Hallway 200	2017		9,466		15	632	632	2,212	32
33	Water Heater	2019		7,255		7	1,036	1,036	1,554	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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57			1,038			(1,038)	
58			69,400			(69,400)	
59			17,565			(17,565)	
60							
61		8,901			214	214	
62		893			57	57	
63							
64							
65							
66							
67							
68							
69							
70		\$ 2,007,512	\$ 88,003		\$ 69,323	\$ (18,680)	\$ 988,447

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

Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$ 39,795	\$ 4,344	\$ 4,905	\$ 561	5-10 yrs.	\$ 4,905	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	393,187					393,187	73
74	Home Office Allocation			4,803	4,803			74
75	TOTALS	\$ 432,982	\$ 4,344	\$ 9,708	\$ 5,364		\$ 398,092	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)	\$ 2,539,471	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,031	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,316)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,415,516	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					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	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.



Facility Name & ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**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

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 114,849 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

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

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

**Swansea Rehab Hlth Care Ctr  
0056374**

**Period Beginning**      1/1/2020  
**Period End**            12/31/2020

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 24,594
Dishwasher	956
Copier	6,781
Home Office Allocation	82,518
	<u>114,849</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	\$	7,987	\$ 119,802	\$	7,987	\$ 119,802	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,227	63,404		4,227	63,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a(2), 10A(3)	hrs		5,882	88,231	185	5,882	88,416	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 prescrpts				36,948		36,948	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)			8	116		8	116	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	18,104	\$ 271,553	\$ 37,133	18,104	\$ 308,686	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.

Facility Name &amp; ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(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	\$ (80,703)	\$ (80,703)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,400 )	4,687,724	4,687,724	3
4	Supply Inventory (priced at Cost )	9,014	9,014	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,412	23,412	6
7	Other Prepaid Expenses	637,960	637,960	7
8	Accounts Receivable (owners or related parties)		4,900	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,277,407	\$ 5,282,307	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		70,000	13
14	Buildings, at Historical Cost		1,743,901	14
15	Leasehold Improvements, at Historical Cost		263,611	15
16	Equipment, at Historical Cost	28,977	461,959	16
17	Accumulated Depreciation (book methods)	(28,977)	(1,415,516)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		98,075	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	159,150	399,314	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	565,160	565,160	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 724,310	\$ 2,186,504	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,001,717	\$ 7,468,811	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 836,838	\$ 836,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,143	56,143	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,607	63,607	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,944	52,944	32
33	Accrued Interest Payable		37,582	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	378	378	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,009,910	\$ 1,047,492	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,133,846	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Intercompany Loans</u>	701,335	715,422	43
44	<u>Loan Payable-MCAD Adv. &amp; SBA PPP</u>	1,305,000	1,305,000	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,006,335	\$ 5,154,268	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,016,245	\$ 6,201,760	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,985,472	\$ 1,267,051	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,001,717	\$ 7,468,811	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,337,054</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>216,537</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>2,553,591</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>431,881</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>431,881</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>2,985,472</b>	<b>24</b> *

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

Facility Name &amp; ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,544,072	1
2	Discounts and Allowances for all Levels	(644,905)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,899,167	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	480,438	6
7	Oxygen	(986)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 479,452	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	1,014	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,443	20
21	Other Medical Services	11,606	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 86,614	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	(285)	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	877,745	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 877,460	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,342,694	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	609,501	31
32	Health Care	2,008,451	32
33	General Administration	673,438	33
<b>B. Capital Expense</b>			
34	Ownership	264,933	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	204,236	35
36	Provider Participation Fee	150,254	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,910,813	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	431,881	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 431,881	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,836,019	44
45	Private Pay - Net Inpatient Revenue	575,730	45
46	Medicare - Net Inpatient Revenue	415,039	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	72,379	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,899,167	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 Rehab Hlth Care Ctr

# 0056374

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	1,193	1,195	\$ 38,293	\$ 32.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,131	1,131	30,442	26.92	3
4	Licensed Practical Nurses	8,121	8,288	197,566	23.84	4
5	CNAs & Orderlies	28,148	28,707	421,200	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,647	1,739	22,846	13.14	9
10	Activity Assistants					10
11	Social Service Workers	2,007	2,071	35,436	17.11	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,318	12.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,562	9,950	104,416	10.49	15
16	Dishwashers					16
17	Maintenance Workers	1,954	2,060	34,493	16.74	17
18	Housekeepers	10,096	10,359	94,763	9.15	18
19	Laundry	3,317	3,397	46,739	13.76	19
20	Administrator	2,024	2,080	90,504	43.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	660	710	8,788	12.38	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	1,934	1,988	49,253	24.78	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,339	3,444	71,442	20.74	33
34	TOTAL (lines 1 - 33)	77,213	79,199	\$ 1,271,499 *	\$ 16.05	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	60	\$ 3,607	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,000	L10, C3	38
39	Pharmacist Consultant	Monthly	4,932	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	30,343	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Telehealth	Monthly	16,190	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 86,072		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	238	\$ 12,885	L10,C3	50
51	Licensed Practical Nurses	14,019	677,191	L10,C3	51
52	Certified Nurse Assistants/Aides			L10,C3	52
53	TOTAL (lines 50 - 52)	14,257	\$ 690,076		53



Swansea Rehab Hlth Care Ctr

0056374

Period Beginning 1/1/2020

Period End 12/31/2020

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	1,200	1,203	36,618	30.44
Transportation	188	188	1,882	10.01
Restorative Aides	1,951	2,053	32,942	16.05
<b>TOTAL</b>	<b>3,339</b>	<b>3,444</b>	<b>71,442</b>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Jifi Jacob	Administrator	0	\$ 90,504	Workers' Compensation Insurance	\$ 22,762	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	19,173	Advertising: Employee Recruitment		
				FICA Taxes	87,093	Health Care Worker Background Check		
				Employee Health Insurance	7,810	(Indicate # of checks performed 6 )		
				Employee Meals		Patient Background Checks	28 837	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,037	
				Employee Relations	1,667	Miscellaneous Dues & Subscriptions	50	
				Home Office Allocation	8,127	Home Office Allocation	2,400	
				Administrator Benefits	18,696			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,504					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 173,400			Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 173,400	TOTAL (agree to Schedule V, line 22, col.8)	\$ 165,328	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,314	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Charter Communications	Computer Services		\$ 1,200				Out-of-State Travel	\$
Ability Network	Computer Services		6,671					
Heather Hopfinger	Legal Settlement		40,000				In-State Travel	
Kathleen Peveto	Legal Settlement		75,000					
Greta Nunn	Legal Settlement		47,500				Seminar Expense	250
St. Clair County Recorder	Title Lien Searches-May 2020		45	N/A			Home Office Allocation	15
Illinois Secretary of State	Legal Filing Fees		155				Entertainment Expense	( )
Livingston, Barger, Brandt	Legal Fees-4/15/20		3,223				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 265
Sector Bank	Title Lien Searches-July 2020		545					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 174,339	TOTAL				

\* Attach copy of IMRF notifications

\*\*See instructions.

Swansea Rehab Hlth Care Ctr

0056374

Period Beginning 1/1/2020  
 Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE  
 C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		174,339
Non-Allowable Legal Settlement		(162,500)
<b>Home Office Allocation</b>		
Baker Tilly Virchow Krause LLP	Legal	271
Duane Morris	Legal	379
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	14
Miller, Hall, Triggs	Legal	47
Miscellaneous	Legal	17
SB2	Legal	140
SmithAmundsen LLC	Legal	866
Sorling Northrup	Legal	247
Applegate & Thorne	Legal	8,375
Baker Tilly Virchow Krause LLP	Legal	789
Boyle Brasher LLC	Legal	869
Bureau Veritas Technical Assessment	Legal	481
Chapman and Keller	Legal	34,004
CliftonLarsonAllen	Legal	2,026
Duane Morris	Legal	68,909
Elias, Meghinnes, Seghetti	Legal	70
Illinois Secretary of State	Legal	96
Lashly & Baer	Legal	954
Livingston, Barger, Brandt, Schroeder	Legal	3,478
Moore, Susler, McNutt, Wrigley	Legal	1,156
Saul Ewing Artstein & Lehr	Legal	260
Sector	Legal	7,419
Sedgwick Claims Management	Legal	22,714
SmithAmundsen	Legal	3,935
Sorling Northrup	Legal	1,014
SPI Corporate Solutions	Legal	11,106
Stanley, Lande and Hunter	Legal	384
CliftonLarsonAllen	Accounting	2,126
Ginoli & Co.	Accounting	1,149
Ability Network	Computer Services	2,763
Allscripts	Computer Services	436
AOD Matrix Care	Computer Services	4,853
AT&T	Computer Services	5
ATS	Computer Services	265
CCH	Computer Services	15
Charter Communications	Computer Services	24
Citrix Systems	Computer Services	82
Comcast	Computer Services	28
ITSavvy	Computer Services	128
Kemper Technology	Computer Services	631
Miscellaneous	Computer Services	122
Pearl Technology	Computer Services	114
Stratus Networks	Computer Services	501
TR Professional	Computer Services	11
David Budde	Other Prof Fees	11
DJ Howard and Associates	Other Prof Fees	21
Getzler Henrich & Associates	Other Prof Fees	85
LRI Consulting Services	Other Prof Fees	83
McQuellon Consulting	Other Prof Fees	52
Miscellaneous	Other Prof Fees	117
Optimizer	Other Prof Fees	45
Registered Agent Solutions	Other Prof Fees	25
RSM McGladrey	Other Prof Fees	274
SB2	Other Prof Fees	350
Sedgwick CMS	Other Prof Fees	472
Tarver Program Consultants	Other Prof Fees	65
D.J. Howard & Associates	Other Prof Fees	904
Creative Health Capital	Other Prof Fees	8,978
Getzler Henrich & Associates	Other Prof Fees	8,470
Health Dimensions	Other Prof Fees	1,206
Mohr & Kerr Engineering and Land Surveying	Other Prof Fees	22,655
SB2	Other Prof Fees	723
Scott Communication Solutions	Other Prof Fees	1,809
Sedgwick Claims Management	Other Prof Fees	6,347
Total (agree to Schedule V, line 19, column 8)		<u>247,811</u>

Swansea Rehab Hlth Care Ctr  
0056374

Period Beginning 1/1/2020  
Period End 12/31/2020

Schedule 21B

**25. Administrative and Staff Transportation**

Gas	\$ 2,050
Auto Repairs	1,044
Mileage-Travel	259
Home Office Allocation	<u>3,358</u>
	<u><u>6,711</u></u>

Facility Name &amp; ID Number Swansea Rehab Hlth Care Ctr

# 0056374

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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. \$ 20,202 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. \$ 150,254  
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. \$ 1,014
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? 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.