



Facility Name & ID Number Swansea Rehabilitation & Health Care Center

# 0048611 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	34,404	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	34,404	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,141	3,423	1,631	21,195	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,141	3,423	1,631	21,195	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.61%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

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 1,631

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center # 0048611 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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	126,574	10,827		137,401		137,401	3,767	141,168		1
2	Food Purchase		105,283		105,283		105,283	(1,872)	103,411		2
3	Housekeeping	80,702	18,429		99,131		99,131	28	99,159		3
4	Laundry	29,845	12,904		42,749		42,749	2	42,751		4
5	Heat and Other Utilities			112,760	112,760		112,760	390	113,150		5
6	Maintenance	31,437	9,561	21,429	62,427		62,427	3,272	65,699		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							926	926		7
8	<b>TOTAL General Services</b>	268,558	157,004	134,189	559,751		559,751	6,513	566,264		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	981,156	63,360	2,161	1,046,677		1,046,677	5,774	1,052,451		10
10a	Therapy		49	205,687	205,736		205,736		205,736		10a
11	Activities	40,646	25	72	40,743		40,743		40,743		11
12	Social Services	38,954	3		38,957		38,957		38,957		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,142	1,142		15
16	<b>TOTAL Health Care and Programs</b>	1,060,756	63,437	215,420	1,339,613		1,339,613	6,916	1,346,529		16
	<b>C. General Administration</b>										
17	Administrative	64,961		119,000	183,961		183,961	(89,673)	94,288		17
18	Directors Fees										18
19	Professional Services			12,580	12,580		12,580	7,719	20,299		19
20	Dues, Fees, Subscriptions & Promotions			8,329	8,329		8,329	2,262	10,591		20
21	Clerical & General Office Expenses	26,893	5,668	17,274	49,835		49,835	41,822	91,657		21
22	Employee Benefits & Payroll Taxes			160,440	160,440		160,440	737	161,177		22
23	Inservice Training & Education			173	173		173	224	397		23
24	Travel and Seminar							307	307		24
25	Other Admin. Staff Transportation			1,916	1,916		1,916	4,792	6,708		25
26	Insurance-Prop.Liab.Malpractice			18,330	18,330		18,330	1,327	19,657		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,478	10,478		27
28	<b>TOTAL General Administration</b>	91,854	5,668	338,042	435,564		435,564	(20,005)	415,559		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,421,168	226,109	687,651	2,334,928		2,334,928	(6,576)	2,328,352		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			139,796	139,796		139,796	(14,843)	124,953			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			141,501	141,501		141,501	22,709	164,210			32
33	Real Estate Taxes			39,457	39,457		39,457	538	39,995			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,756	14,756		14,756	571	15,327			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			335,510	335,510		335,510	8,975	344,485			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,261		46,261		46,261		46,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,606	51,606		51,606		51,606			42
43	Other (specify):* Non-allowable Cost		209	171,189	171,398		171,398	(171,398)				43
44	<b>TOTAL Special Cost Centers</b>		46,470	222,795	269,265		269,265	(171,398)	97,867			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,421,168	272,579	1,245,956	2,939,703		2,939,703	(168,999)	2,770,704			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	(1,934)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,225)	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	(33,990)	30		9
10	Interest and Other Investment Income	(1,433)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	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	(13,965)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(149,281)	43		24
25	Fund Raising, Advertising and Promotional	(2,654)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(5,836)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (210,517)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,518	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 41,518		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (168,999)		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

## Swansea Rehabilitation &amp; Health Care Center

ID# 0048611

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,228)	43	1
2	X-Rays-Part A	(1,781)	43	2
3	Disallowed Special Events	(65)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(672)	21	4
5	Disallowed Chamber of Commerce Dues	(325)	20	5
6	Offset Miscellaneous Nursing Supplies Revenue	(765)	10	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,836)		49

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

**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, Inc.	100.00%	\$ 3,767	\$ 3,767	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	62	62	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	28	28	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	390	390	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,302	2,302	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	926	926	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,539	6,539	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,142	1,142	10
11	V	17 Administrative	119,000	Petersen Health Care, Inc.	100.00%	29,327	(89,673)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,310	3,310	12
13	V							13
14	Total		\$ 119,000			\$ 47,795	\$ * (71,205)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,021	\$	1,021	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,803		36,803	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	224		224	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	224		224	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,898		2,898	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	176		176	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,478		10,478	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,010		4,010	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,820		2,820	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	538		538	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	459		459	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		\$			\$ 59,651	\$ *	59,651	39

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611Report Period Beginning: 1/1/2008Ending: 12/31/2008

## 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, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	970	970	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	4,409	4,409	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,566	1,566	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	5,691	5,691	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	737	737	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	83	83	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	1,894	1,894	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,151	1,151	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	15,137	15,137	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	21,322	21,322	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	112	112	38	
39	Total		\$			\$ 53,072	\$ *	53,072	39

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

Facility Name & ID Number Swansea Rehabilitation & Health Care Cent # 0048611 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

## 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	Mark Petersen	President	Administrative	100.00	1,799,347	0.88	1.47	Salary	\$ 29,327	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 29,327		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:

1/1/2008Ending: 2/31/2008

## 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, 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	1,413,604	69	\$ 251,260	\$ 250,687	21,195	\$ 3,767	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	21,195	62	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	21,195	28	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	21,195	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	21,195	390	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	21,195	2,302	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	21,195	926	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	21,195	6,539	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	21,195	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	21,195	1,142	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	21,195	29,327	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	21,195	3,310	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	21,195	1,021	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	21,195	36,803	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	21,195	224	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	21,195	224	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	21,195	2,898	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	21,195	176	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	21,195	10,478	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	21,195	4,010	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	21,195	2,820	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	21,195	538	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	21,195	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	21,195	459	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 107,446	25

Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611

Report Period Beginning:

1/1/2008Ending: 2/31/2008

## 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 II, 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	331,413	13	\$	21,195	\$	1
2	2	Food	Resident Days	331,413	13		21,195		2
3	3	Housekeeping	Resident Days	331,413	13		21,195		3
4	4	Laundry	Resident Days	331,413	13		21,195		4
5	5	Utilities	Resident Days	331,413	13		21,195		5
6	6	Maintenance	Resident Days	331,413	13	15,163	21,195	970	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,195		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		21,195		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,195		9
10	17	Administrative	Resident Days	331,413	13		21,195		10
11	19	Professional Services	Resident Days	331,413	13	68,939	21,195	4,409	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	21,195	1,566	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	21,195	5,691	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	21,195	737	14
15	23	Inservice Training & Education	Resident Days	331,413	13		21,195		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	21,195	83	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	21,195	1,894	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	21,195	1,151	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,195		19
20	30	Depreciation	Resident Days	331,413	13	236,686	21,195	15,137	20
21	32	Interest	Resident Days	331,413	13	333,393	21,195	21,322	21
22	33	Real Estate Taxes	Resident Days	331,413	13		21,195		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		21,195		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	21,195	112	24
25	TOTALS					\$ 829,849	\$	\$ 53,072	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10			
										Related**		Purpose of Loan
Name of Lender	YES	NO	Original	Balance								
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	US Bank		X	Mortgage	Varies	12/14/07	\$ 1,788,000	\$ 1,745,464	12/31/11	Varies	\$ 129,731	1
2												2
3							Interest Income Offset				(1,433)	3
4							Home Office Allocation-PHC				2,820	4
5							Home Office Allocation-PHC II				21,322	5
<b>Working Capital</b>												
6	Associated Bank		X	Working Capital	Interest Only	1/1/08	250,000	N/A	Paid Off	0.0875	8,170	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 2,038,000	\$ 1,745,464			\$ 160,610	9
<b>B. Non-Facility Related*</b>												
10							Amortization Expense on Loan Costs				3,600	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 3,600	14
15	<b>TOTALS (line 9+line14)</b>						\$ 2,038,000	\$ 1,745,464			\$ 164,210	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 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 Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-16,0-409-014</u>	<u>Long-Term Care Facility</u>	\$ <u>38,456.70</u>	\$ <u>38,456.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>38,456.70</u>	\$ <u>38,456.70</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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

1/1/2008

Ending:

12/31/2008

**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?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>100,800</u>	<u>2006</u>	<u>\$ 70,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>100,800</b>		<b>\$ 70,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	\$ 144,583	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Sidewalk		2006	500		10	50	50	125	9
10	Landscaping		2007	1,685		15	56	56	112	10
11	Carpeting		2007	1,637		10	164	164	246	11
12	Awning		2007	815		10	82	82	123	12
13	Blinds		2007	1,883		10	188	188	282	13
14	Signage		2007	2,770		10	277	277	416	14
15	Roof Top Air Conditioners		2007	16,613		10	1,661	1,661	2,492	15
16	Landscaping		2008	3,385		15	113	113	113	16
17	Water Heater		2008	8,724		5	872	872	872	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28	Building Booked				69,400			(69,400)		28
29	Building Improvement Booked				7,897			(7,897)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			736			47	47		32
33	2008-Home Office Allocation-Building Improvements			11,005			264	264		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 Depreciation-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								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 378,333	\$ 55,975	\$ 37,833	\$ (18,142)	7-10 yrs.	\$ 91,522	71
72	Current Year Purchases	11,428	729	571	(158)	10 yrs.	571	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,147	19,147			74
75	TOTALS	\$ 389,761	\$ 56,704	\$ 57,551	\$ 847		\$ 92,093	75

D. Vehicle Depreciation (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	\$ 3,381	\$ 5,795	\$ 2,414	5	\$ 8,693	76
77										77
78										78
79										79
80	TOTALS			\$ 28,977	\$ 3,381	\$ 5,795	\$ 2,414		\$ 8,693	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)	\$ 2,273,491	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 137,382	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,953	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,429)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 250,150	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	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	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 15,327 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

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

**Swansea Rehabilitation & Health Care Center**

**0048611**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 14,048
Dishwasher	708
Home Office Allocation	571
	<u>15,327</u>
	<u><u>15,327</u></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>It is the policy of this facility to only hire certified nurses aides. 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		3	4
		1	2		
		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	\$		\$ 73,570	\$		\$ 73,570	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			36,807			36,807	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs			95,210	49		95,259	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				46,261		46,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>				7	100		7	100	13
14	<b>TOTAL</b>			\$	7	\$ 205,687	\$ 46,310	7	\$ 251,997	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 & ID Number Swansea Rehabilitation & Health Care Center

# 0048611

Report Period Beginning: 1/1/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (1,378,553)	\$ (1,378,553)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	1,155,021	1,155,021	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,376	23,376	6
7	Other Prepaid Expenses	10,807	10,807	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (189,349)	\$ (189,349)	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	1,810,570	1,746,005	14
15	Leasehold Improvements, at Historical Cost	67,442	38,748	15
16	Equipment, at Historical Cost	422,164	418,738	16
17	Accumulated Depreciation (book methods)	(312,119)	(250,150)	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: <u>Loan Costs</u> )	10,800	10,800	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,998,857	\$ 2,034,141	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,809,508	\$ 1,844,792	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 530,074	\$ 530,074	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,146	85,146	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,782	4,782	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	10,192	10,192	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	22,326	22,326	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 692,520	\$ 692,520	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,745,464	1,745,464	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>	\$ 1,745,464	\$ 1,745,464	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,437,984	\$ 2,437,984	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (628,476)	\$ (593,192)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,809,508	\$ 1,844,792	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (202,102)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	(1)	<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>	\$ (202,103)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(426,373)	<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>	\$ (426,373)	<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>	\$ (628,476)	<b>24</b> *

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

**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

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,004,969	1
2	Discounts and Allowances for all Levels	112,049	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,117,018	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	297,188	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 297,188	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	1,934	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,459	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,781	20
21	Other Medical Services	2,080	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 96,254	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,433	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,433	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	1,437	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,437	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,513,330	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	559,751	31
32	Health Care	1,339,613	32
33	General Administration	435,564	33
	<b>B. Capital Expense</b>		
34	Ownership	335,510	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	217,659	35
36	Provider Participation Fee	51,606	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,939,703	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(426,373)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (426,373)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

\*\*\* 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: 1/1/2008

Ending:

12/31/2008

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	1,789	1,829	\$ 46,074	\$ 25.19	1
2	Assistant Director of Nursing	1,032	1,112	23,952	21.54	2
3	Registered Nurses	2,719	2,831	66,468	23.48	3
4	Licensed Practical Nurses	13,565	13,967	282,730	20.24	4
5	CNAs & Orderlies	50,132	51,161	488,567	9.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,750	2,806	40,646	14.49	9
10	Activity Assistants					10
11	Social Service Workers	2,980	2,980	38,954	13.07	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,322	14.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,197	10,604	96,252	9.08	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	31,437	15.11	17
18	Housekeepers	9,178	9,410	80,702	8.58	18
19	Laundry	3,432	3,439	29,845	8.68	19
20	Administrator	2,080	2,081	64,961	31.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	26,893	12.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	35,079	16.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,807	1,807	38,286	21.19	33
34	TOTAL (lines 1 - 33)	109,981	112,347	\$ 1,421,168 *	\$ 12.65	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 7,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,000	10(3)	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)	\$ 8,500		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53



**Swansea Rehabilitation & Health Care Center**

**0048611**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**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)		12,580

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	120
GoffWilson, P.A.	Legal	402
U.S. Bank	Legal	701
Ginoli & Company	Accountants	3,531
RSM McGladrey	Accountants	9
U.S. Bank	Accountants	430
Miscellaneous Vendors	Computer Services	47
Emdeon Business Services	Computer Services	65
Advanced Answers on Demand	Computer Services	761
Access 2 Go	Computer Services	224
Ivans	Computer Services	625
Kemper Technology	Computer Services	412
VisionShare	Computer Services	44
Logmeln	Computer Services	32
Comm Net Communiations	Computer Services	12
Charter Communications	Computer Services	10
Advanced System Designs	Computer Services	15
Consolidated Communications	Computer Services	9
CDW	Computer Services	214
Miscellaneous Vendors	Miscellaneous	56

Total (agree to Schedule V, line 19, column 8)	<u><u>20,299</u></u>
--	----------------------



Facility Name & ID Number Swansea Rehabilitation & Health Care Center# 0048611Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 2,750 -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? No
- (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? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 116 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? N/A  
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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,606  
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. \$ 1,934
- (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. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees