

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>I. IDPH License ID Number: <u>0035485</u></p> <p>Facility Name: <u>Swann Special Care Center</u></p> <p>Address: <u>109 Kenwood Road</u> <u>Champaign</u> <u>61821</u> Number City Zip Code</p> <p>County: <u>Whiteside</u></p> <p>Telephone Number: <u>(217) 356-5164</u> Fax # <u>(217) 356-7873</u></p> <p>HFS ID Number: <u>31-1262572</u></p> <p>Date of Initial License for Current Owners: <u>08/15/89</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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>IRS Exemption Code <u>501 (c)(3)</u></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 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>In the event there are further questions about this report, please contact: Name: <u>Kylie Waters Whipple</u> Telephone Number: <u>(859) 255-0075</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/08</u> to <u>6/30/09</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 rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>James R. Johnson</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>V.P. of Finance - Medical Rehabilitation Centers, Inc.</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Rick Mittman</u> <u>Senior Managing Consultant</u></td> </tr> <tr> <td>(Firm Name & Address) <u>BKD, LLP</u> <u>201 North Illinois Street, Suite 700, Indianapolis, IN 46244</u></td> </tr> <tr> <td>(Telephone) <u>(317) 383-4000</u> Fax # <u>(317) 383-4200</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>James R. Johnson</u> (Date) _____		(Title) <u>V.P. of Finance - Medical Rehabilitation Centers, Inc.</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>Rick Mittman</u> <u>Senior Managing Consultant</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>201 North Illinois Street, Suite 700, Indianapolis, IN 46244</u>	(Telephone) <u>(317) 383-4000</u> Fax # <u>(317) 383-4200</u>	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
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Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 7/1/08 Ending: 6/30/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>44,895</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>41,954</u>	<u>730</u>	<u>37</u>	<u>42,721</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,954</u>	<u>730</u>	<u>37</u>	<u>42,721</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.16%

D. How many bed-hold days during this year were paid by the Department? 645 (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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 8/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/15/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/08 Ending: 6/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	230,869	27,212	19,364	277,445	14,471	291,916	(72,319)	219,597		1
2	Food Purchase		293,168		293,168		293,168		293,168		2
3	Housekeeping		34,709	139,108	173,817		173,817		173,817		3
4	Laundry	33,820	25,385	97,694	156,899		156,899		156,899		4
5	Heat and Other Utilities			97,816	97,816	1,398	99,214		99,214		5
6	Maintenance	58,165	17,764	56,371	132,300	16,699	148,999	(914)	148,085		6
7	Other (specify):*										7
8	TOTAL General Services	322,854	398,238	410,353	1,131,445	32,568	1,164,013	(73,233)	1,090,780		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,663,158	243,772	119,107	3,026,037	(12,107)	3,013,930		3,013,930		10
10a	Therapy	59,823	1,249	140,300	201,372		201,372		201,372		10a
11	Activities	192,103	1,588	1,319	195,010		195,010		195,010		11
12	Social Services	2,655	80	2,066	4,801		4,801		4,801		12
13	CNA Training					30,281	30,281		30,281		13
14	Program Transportation	59,794	10,179	16,780	86,753		86,753		86,753		14
15	Other (specify):* Ward Clerk	22,779			22,779		22,779		22,779		15
16	TOTAL Health Care and Programs	3,000,312	256,868	315,572	3,572,752	18,174	3,590,926		3,590,926		16
	C. General Administration										
17	Administrative	75,860		240,589	316,449	(224,714)	91,735	(15,875)	75,860		17
18	Directors Fees					8,671	8,671		8,671		18
19	Professional Services			710,014	710,014	81,231	791,245	(1,062)	790,183		19
20	Dues, Fees, Subscriptions & Promotions			13,668	13,668	296	13,964	(2,658)	11,306		20
21	Clerical & General Office Expenses	119,089	18,801	64,227	202,117	46,442	248,559	(50)	248,509		21
22	Employee Benefits & Payroll Taxes			714,629	714,629	13,380	728,009		728,009		22
23	Inservice Training & Education										23
24	Travel and Seminar			23,335	23,335	(285)	23,050	(741)	22,309		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,071	57,071		57,071		57,071		26
27	Other (specify):* Bad Debt			36,969	36,969		36,969	(36,969)			27
28	TOTAL General Administration	194,949	18,801	1,860,502	2,074,252	(74,979)	1,999,273	(57,355)	1,941,918		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,518,115	673,907	2,586,427	6,778,449	(24,237)	6,754,212	(130,588)	6,623,624		29

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

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

Facility Name & ID Number Swann Special Care Center

#0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			195,131	195,131	148	195,279		195,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			480,829	480,829	38,557	519,386	(117,347)	402,039			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					2,370	2,370		2,370			34
35	Rent-Equipment & Vehicles			10,759	10,759	(603)	10,156		10,156			35
36	Other (specify):* Amortization			41,239	41,239		41,239	(30,315)	10,924			36
37	TOTAL Ownership			727,958	727,958	40,472	768,430	(147,662)	620,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			402,801	402,801		402,801		402,801			42
43	Other (specify):* Edu/Day Training	1,107,490	9,491	317,895	1,434,876	(16,235)	1,418,641		1,418,641			43
44	TOTAL Special Cost Centers	1,107,490	9,491	720,696	1,837,677	(16,235)	1,821,442		1,821,442			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,625,605	683,398	4,035,081	9,344,084		9,344,084	(278,250)	9,065,834			45

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(28,825)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,062)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,969)	27		24
25	Fund Raising, Advertising and Promotional	(2,443)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(193,026)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (262,375)		\$	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)			34
35	Other- Attach Schedule	(15,875)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,875)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (278,250)		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.		X	\$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Swann Special Care Center

ID# 0035485

Report Period Beginning: 7/1/08

Ending: 6/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$ (72,319)	1	1
2		(27,835)	36	2
3		(2,480)	36	3
4		(741)	24	4
5		(914)	6	5
6		(88,522)	32	6
7		(215)	20	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
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(193,026)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(72,319)	0	0	0	0	0	0	0	0	0	0	(72,319)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(914)	0	0	0	0	0	0	0	0	0	0	(914)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(73,233)	0	0	0	0	0	0	0	0	0	0	(73,233)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(15,875)	0	0	0	0	0	0	0	0	0	(15,875)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,062)	0	0	0	0	0	0	0	0	0	0	(1,062)	19
20	Fees, Subscriptions & Promotions	(2,658)	0	0	0	0	0	0	0	0	0	0	(2,658)	20
21	Clerical & General Office Expenses	(50)	0	0	0	0	0	0	0	0	0	0	(50)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(741)	0	0	0	0	0	0	0	0	0	0	(741)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(36,969)	0	0	0	0	0	0	0	0	0	0	(36,969)	27
28	TOTAL General Administration	(41,480)	(15,875)	0	(57,355)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(114,713)	(15,875)	0	(130,588)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(117,347)	0	0	0	0	0	0	0	0	0	0	(117,347)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(30,315)	0	0	0	0	0	0	0	0	0	0	(30,315)	36
37	TOTAL Ownership	(147,662)	0	0	0	0	0	0	0	0	0	0	(147,662)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(262,375)	(15,875)	0	0	0	0	0	0	0	0	0	(278,250)	45

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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
		Exceptional Care & Training Center	Sterling			
		Vernon Manor Children's Home	Wabash, Indiana			
		Walter Lawson Children's Home	Loves Park			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	Brazil, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

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	17 Corporate Expense	\$ 240,589	Hoosier Care, Inc.	100.00%	\$ 224,714	\$ (15,875)	1
2	V							2
3	V			Note: See Schedule VIII of allocation of cost per column 7.				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 240,589			\$ 224,714	\$ * (15,875)	14

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

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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	Bruce Hutson, M.D.	Director	Board Meetings	0.00	8,177			Director Fees	\$ 2,476	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	6,821			Director Fees	2,065	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	6,821			Director Fees	2,065	18.8	3
4	John Foos	Director	Board Meetings	0.00	6,821			Director Fees	2,065	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,671		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

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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 Hoosier Care, Inc.
 Street Address 535 West Second Street, Suite 105
 City / State / Zip Code Lexington, Kentucky 40508
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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	Revenue	44,383,677	8	\$ 62,270	\$ 0	10,314,387	\$ 14,471	1
2	5	Heat & Other Utilities	Revenue	44,383,677	8	6,014	0	10,314,387	1,398	2
3	6	Maintenance	Revenue	44,383,677	8	5,552	0	10,314,387	1,290	3
4	10	Nursing / Medical Records	Revenue	44,383,677	8	69,216	0	10,314,387	16,085	4
5	18	Directors Fees	Revenue	44,383,677	8	37,311	0	10,314,387	8,671	5
6	19	Professional Services	Revenue	44,383,677	8	349,543	0	10,314,387	81,231	6
7	20	Dues, Subscriptions & Fees	Revenue	44,383,677	8	1,272	0	10,314,387	296	7
8	21	Clerical & General Office Exp.	Revenue	44,383,677	8	200,276	0	10,314,387	46,542	8
9	22	Emp. Benefits & Payroll Tax	Revenue	44,383,677	8	57,575	0	10,314,387	13,380	9
10	24	Travel & Seminar	Revenue	44,383,677	8	1,182	0	10,314,387	275	10
11	30	Depreciation	Revenue	44,383,677	8	635	0	10,314,387	148	11
12	32	Interest - Working Capital	Revenue	44,383,677	8	165,913	0	10,314,387	38,557	12
13	34	Rent- Facility	Revenue	44,383,677	8	10,200	0	10,314,387	2,370	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 966,959	\$		\$ 224,714	25

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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	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Ill. Health Finance Authority	X	Purchase of Facility	Varies	7/8/99	\$ 5,710,000	\$ 5,165,000	6/1/2034	7.1250	\$ 371,657	1								
2	Ill. Health Finance Authority	X	Purchase of Facility	Varies	7/8/99	260,000	190,000	6/2/2019	10.5000	20,650	2								
3											3								
4											4								
5											5								
Working Capital																			
6	Corporate Allocation									38,557	6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 5,970,000	\$ 5,355,000			\$ 430,864	9								
B. Non-Facility Related*																			
10	Debt Allocation	X	Purchase of Facility	Varies	7/8/99		1,207,016	Varies	Varies	88,522	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$ 1,207,016			\$ 88,522	14								
15	TOTALS (line 9+line14)					\$ 5,970,000	\$ 6,562,016			\$ 519,386	15								

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,257 B. General Construction Type: Exterior Block & Brick Frame Wood 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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>SNF/PED</u>	<u>89,603</u>	<u>1989</u>	<u>\$ 538,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	89,603		\$ 538,000	3

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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	87		1989	1975	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,461,809	4
5	9			1993	319,955	10,665	30	10,665		193,182	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		46,064	7
8	11			2004	N/A		N/A				8
	Improvement Type**										
9	Paint & Panels		1989		1,308		3			1,308	9
10	Blinds		1990		384		3			384	10
11	Fire Doors		1990		2,751		10			2,751	11
12	Storm Windows		1991		4,224		10			4,224	12
13	Fire Doors		1991		3,675		10			3,675	13
14	Compressor		1991		1,035		10			1,035	14
15	Carpeting		1991		220		10			220	15
16	Sprinkler & Fire Alarm		1991		695		10			695	16
17	Sprinkler		1992		3,162		10			3,162	17
18	Damper		1992		674		10			674	18
19	Fire Alarm System		1992		1,945		10			1,945	19
20	Water Heater		1992		1,998		7			1,998	20
21	Roofing		1992		3,900		10			3,900	21
22	Voltage Relay		1993		1,875		10			1,875	22
23	Sprinkler System		1993		14,460		10			14,460	23
24	Wall Covering		1993		3,190		10			3,190	24
25	Wall Papering		1993		3,000		10			3,000	25
26	Blinds with Valance		1993		2,395		10			2,395	26
27	Carpet and Rubber Base		1993		2,848		10			2,848	27
28	Replace Siding		1993		575		10			575	28
29	Remodeling in Team Rooms		1993		9,405		10			9,405	29
30	Plexiglas for Doors & Walls		1993		714		10			714	30
31	Resurface Parking Lot		1993		19,115		10			19,115	31
32	Shed		1993		5,990		10			5,990	32
33	Stain New Shed		1993		1,248		10			1,248	33
34	Fire Doors, Closets, Tile		1993		5,225		10			5,225	34
35	Architectural Renovation		1993		855		10			855	35
36	Install Alarm & Nurse Call		1994		688		10			688	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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Heat Pump	1994	\$ 2,017	\$	10	\$	\$	\$ 2,017	37
38	Paving for New Sign	1994	680		10			680	38
39	Labor for Laying Brick - Sign	1994	1,000		10			1,000	39
40	Sign for Dedication	1994	325		10			325	40
41	Sign and Granite Pieces	1994	1,300		10			1,300	41
42	Material for Leasehold Improvements	1995	7,858		3			7,858	42
43	Hoods, Fans, Ansul System	1995	2,500		10			2,500	43
44	Work for Exhaust Fan & Hood	1995	3,995		10			3,995	44
45	Day Room Addition	1995	3,337		10			3,337	45
46	Replace Water Heater	1995	3,750		10			3,750	46
47	Day Room Additional Supplies	1995	1,926		10			1,926	47
48	Walk-in-Cooler	1995	3,334		10			3,334	48
49	Nurse Call System	1996	1,198		10			1,198	49
50	Shed	1996	2,034		10			2,034	50
51	Air Conditioner Compressor	1996	1,208		10			1,208	51
52	Supplies for Leasehold Improvements	1996	3,091		3			3,091	52
53	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose								53
54	Activity Room & Bathroom Addition plus renovation								54
55	to the Dental Office	1996	180,928	9,046	20	9,046		119,864	55
56	Construct Screens, Wheelchairs	1996	1,420		3			1,420	56
57	Construct Shelving, Beds, Screen	1996	2,964		3			2,964	57
58	Install Nurse Call System	1996	1,530		10			1,530	58
59	Tile Flooring & Adhesive	1996	1,227		10			1,227	59
60	Linoleum Flooring	1996	686		10			686	60
61	Install New Drain Pipes	1996	2,190		10			2,190	61
62	Remove Concrete to Replace Drain Pipes	1996	575		10			575	62
63	Install Exit Door Hardware	1997	874		10			874	63
64	Day Training Improvement	1997	4,078		4			4,078	64
65	Install New Disposal	1997	1,069		10			1,069	65
66	Replace Four-Door Glass	1998	520		10			520	66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		4,919	67
68	Remodel Project 2410 Springfield	1998	33,764		4			33,764	68
69	Partition Wall Kitchen / Dining Area	1998	595		8			595	69
70	TOTAL (lines 4 thru 69)		\$ 3,448,638	\$ 81,711		\$ 81,711	\$	\$ 2,014,437	70

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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,448,638	\$ 81,711		\$ 81,711	\$	\$ 2,014,437	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	736	10	736		17,650	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	31	10	31		740	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	636	10	636		15,258	4
5	Security Door and Hardware - Converted Rooms	1999	520	31	10	31		520	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	250	10	250		3,000	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	86	10	86		1,155	7
8	Electrical Service Move Switches	1999	141		8			141	8
9	Installation of Water Heaters	1999	595	49	10	49		595	9
10	Resurface Parking Lot	1999	2,350	157	15	157		1,554	10
11	14 Almond FRP Panel Dividers	1999	513		5			513	11
12	Install Alarm System	2000	2,000		5			2,000	12
13	Install Alarm System	2000	2,730		5			2,730	13
14	Replaced Compressor on Freezer	1999	635	63	10	63		624	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		389	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		2,713	16
17	Storage Barn	1999	120	5	25	5		47	17
18	Storage Barn	1999	1,045	42	25	42		407	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		1,487	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		597	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		2,045	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		7,042	22
23	Install Clinical Sink	2000	3,030		5			3,030	23
24	Stoneybrook Remodeling PR	2000	138,235		5			138,235	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		2,417	25
26	Replace Gate Valve	2000	6,005	400	15	400		3,536	26
27	Replace Ceiling Tile	2000	674	67	10	67		595	27
28	Materials to Tile Bathroom	2001	784	78	10	78		673	28
29	Install Booster Pump	2001	1,995	133	15	133		1,130	29
30	Install Tile in Bathroom	2001	825	55	15	55		467	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		1,802	31
32	Replace Reversing Valve	2001	599	60	10	60		489	32
33	Replacement Parts for Roof	2001	662	66	10	66		540	33
34	TOTAL (lines 1 thru 33)		\$ 3,679,880	\$ 86,641		\$ 86,641	\$	\$ 2,228,561	34

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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,679,880	\$ 86,641		\$ 86,641	\$	\$ 2,228,561	1
2	Tile for Bathroom	2001	1,854	185	10	185		1,499	2
3	Stoneybrook Awning	2001	15,560		5			15,560	3
4	Stoneybrook Telephone System	2001	1,668		5			1,668	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431		5			2,431	5
6	Stoneybrook Shelves - Inst	2001	516		5			516	6
7	Remodeling	2001	8,351		5			8,351	7
8	Sprinkler System Renovation	2001	760	51	15	51		405	8
9	Install Shower Drains	2001	10,500	525	20	525		4,200	9
10	Tile to Replce Tubs	2001	1,278	85	15	85		682	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		1,111	11
12	Replace Laundry Panel	2001	1,179	79	15	79		609	12
13	Valve-Water Heater	2001	876	88	10	88		679	13
14	Internet Set-up Wiring Cable	2002	6,141	409	15	409		3,036	14
15	Thermostats with Locking Guards	2002	1,371	91	15	91		655	15
16	Classroom Remodel	2002	5,978	598	10	598		4,384	16
17	Replace Fencing Around Dumpster Area	2002	674	67	10	67		483	17
18	Replace Doors	2002	3,000		5			3,000	18
19	Security System	2002	3,165		5			3,165	19
20	Remodeling	2002	8,351		5			8,351	20
21	Electrical Labor-Remodeling	2002	1,425		5			1,425	21
22	Install Two Sinks	2002	3,561		5			3,561	22
23	Revise Sprinkler System	2002	501		5			501	23
24	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		1,967	24
25	Install New Phone System	2002	2,735		5			2,735	25
26	Install New Phone System / Day Training	2002	2,488		5			2,488	26
27	Carpet & Installation	2002	2,954	295	10	295		2,068	27
28	New Mother Board / Alarm System	2002	1,490	149	10	149		1,031	28
29	Install A/C Rooftop Unit	2002	8,237	549	15	549		3,798	29
30	New 2nd Rooftop Compressor	2002	762	51	15	51		347	30
31	Height Adjustment Supine Tub	2002	8,469	847	10	847		5,576	31
32	Relief Valves / Booster Heater	2003	555	56	10	56		361	32
33	Central Heat / Air Rooftop	2003	5,180	345	15	345		2,245	33
34	TOTAL (lines 1 thru 33)		\$ 3,796,104	\$ 91,532		\$ 91,532	\$	\$ 2,317,449	34

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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,796,104	\$ 91,532		\$ 91,532	\$	\$ 2,317,449	1
2	New Tile and Base Floor	2003	847	85	10	85		550	2
3	New Hydrotherapy Tub	2003	1,900	190	10	190		1,235	3
4	Electric Water Heater	2003	5,600	560	10	560		3,547	4
5	Exhaust Fan	2003	525	53	10	53		319	5
6	Remodeling	2003	8,351		5			8,351	6
7	Install Dry Pendent Sprinkler in Freezer	2003	675	68	10	68		399	7
8	Rooftop Unit Installed / Heat Air Wing 3	2003	10,910	727	15	727		4,303	8
9	60 X 94 Lami Glass	2003	179,834	5,994	30	5,994		31,970	9
10	New Wing	2004	839	120	7	120		679	10
11	Installing Draining System in Courtyard	2004	9,268	1,324	7	1,324		7,171	11
12	5th Annual Payment on Remodeling	2004	8,351	835	5	835		8,351	12
13	Drainage System for Courtyard	2004	501	72	7	72		370	13
14	Lift Pump for Drinking Fountain	2004	1,040	191	5	191		1,040	14
15	AC Compressor Roof Top Main Building	2004	1,403	281	5	281		1,380	15
16	HVAC Compressor - Office	2004	1,079	216	5	216		1,061	16
17	New Roof	2004	28,855	1,443	20	1,443		7,094	17
18	Exhaust Fan Motor / Thermostat	2005	787	79	10	79		334	18
19	Roofing Project Wing 1,2,&4	2005	66,485	4,432	15	4,432		18,099	19
20	Replace 8 Vinyl Windows	2006	668	67	10	67		223	20
21	Re-Tile Shower Room	2006	10,714	714	15	714		2,262	21
22	Deposit for Duro Last Roof	2006	10,000	667	15	667		2,000	22
23	Compressor for A/C Unit Wing 2	2006	1,506	151	10	151		439	23
24	Duro Last Roof - Payment # 2	2006	4,384	292	15	292		877	24
25	100 Amp Sub Panel	2006	2,650	177	15	177		486	25
26	Laundry Room Walls Replaced	2006	2,323	155	15	155		439	26
27	Re-Tile Shower Room # 10	2006	11,642	776	15	776		2,134	27
28	Re-Tile Shower Room # 3	2006	11,642	776	15	776		2,005	28
29	Re-Tile Shower Room # 4	2006	11,642	776	15	776		1,940	29
30	Replace Walls in Dishwasher Area	2006	7,477	498	15	498		1,288	30
31	Dedicated Ground Circuit & Four Outlets	2006	1,513	101	15	101		252	31
32	Replace Kitchen Ceiling Tiles	2006	552	37	15	37		104	32
33	Parking Lot / Dumpster Pad Repaved	2006	8,073	807	10	807		2,153	33
34	TOTAL (lines 1 thru 33)		\$ 4,208,140	\$ 114,196		\$ 114,196	\$	\$ 2,430,302	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,208,140	\$ 114,196		\$ 114,196	\$	\$ 2,430,302	1
2	Fence / Dumpster Enclosure	2006	2,750	275	10	275		688	2
3	Re-Tile Shower Room #s 5,6,7	2007	12,746	850	15	850		1,983	3
4	Curb & Guardrail Around Dumpster Area	2007	2,400	240	15	240		520	4
5	Metal Panels for School Windows	2007	2,158	144	15	144		312	5
6	15 Amp Receptacles	2007	780	52	15	52		113	6
7	Dedicated Ground Circuit for Server	2007	2,400	160	15	160		360	7
8	Electrical Outlets in Family Room	2007	1,222	81	15	81		176	8
9	Re-Tile Team 6 Bathroom	2007	7,561	504	15	504		924	9
10	Replace Motors on Roof Exhaust Fans (7)	2007	2,667	267	10	267		511	10
11	Upgrade Lighting System in Education	2007	6,501	433	15	433		795	11
12	Remodel Employee Breakroom	2007	2,478	248	10	248		434	12
13	Wire Breakroom & Outlets for Nurses Station	2007	2,574	172	15	172		272	13
14	Window on East Side of Education Building	2008	640	43	15	43		64	14
15	Air Curtain for Laundry Room	2008	1,195	119	10	119		159	15
16	Rooftop Heat Exchange Replaced	2008	2,463	246	10	246		349	16
17	South & Northwest Heat Exchangers	2008	2,421	242	10	242		323	17
18	Replace 2 Doors in Laundry Area	2008	4,187	279	15	279		372	18
19	Plexiglass Window Pane Replaced	2008	527	53	10	53		61	19
20	Remodel Conference Room	2008	2,536	254	10	254		254	20
21	Lift Sunken Sidewalks	2008	1,595	146	10	146		146	21
22	Blower Motor For Rtu #5	2008	1,019	85	10	85		85	22
23	Sprinklers In Conference Room Reconfigured	2008	621	31	15	31		31	23
24	220 Outlet For Stove In Multi-Purpose Room	2008	1,148	51	15	51		51	24
25	Addtnl Outlets (4 Ea.) In Rooms 5,6,8,9,10	2008	7,625	297	15	297		297	25
26	220 Outlet For Stove In Paige II	2008	1,148	34	20	34		34	26
27	Anti-Scald Valve	2009	761	19	10	19		19	27
28	Drainage System For Courtyard	2009	2,250	13	15	13		13	28
29	Rounding		2	(3)		(3)		3	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,284,515	\$ 119,531		\$ 119,531	\$	\$ 2,439,651	34

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	\$ 286,068	\$ 48,125	\$ 48,125	\$		\$ 129,813	71
72	Current Year Purchases	81,052	8,035	8,035			8,035	72
73	Fully Depreciated Assets	632,650	2,265	2,265			632,650	73
74	Corporate Allocation		148	148				74
75	TOTALS	\$ 999,770	\$ 58,573	\$ 58,573	\$		\$ 770,498	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	Patient Transportation	1985 GMC Bus	1993	\$ 5,450	\$	\$	\$		\$ 5,450	76
77	Patient Transportation	1985 GMC Bus	N/A	4,041					4,041	77
78	Patient Transportation	1994 Ford Station Wagon	1999	7,020					7,020	78
79	See Attached			179,011	17,175	17,175			79,202	79
80	TOTALS			\$ 195,522	\$ 17,175	\$ 17,175	\$		\$ 95,713	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)	\$ 6,017,807	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,279	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,305,862	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					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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

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	<u>Corporate Allocation</u>				<u>2,370</u>			5
6								6
7	TOTAL				\$ <u>2,370</u>			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: \$ 10,156 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/08 Ending: 6/30/09
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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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		100		100
3	Classroom Wages (a)		8,944		8,944
4	Clinical Wages (b)		17,889		17,889
5	In-House Trainer Wages (c)		2,788		2,788
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		560		560
9	TOTALS	\$	\$ 30,281	\$	\$ 30,281
10	SUM OF line 9, col. 1 and 2 (e)	\$	30,281		

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	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	26

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$				\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$				\$		\$				\$		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 Swann Special Care Center# 0035485Report Period Beginning: 7/1/08Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,568	\$	1
2	Cash-Patient Deposits	100,205		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>33,801</u>)	3,032,312		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,268		6
7	Other Prepaid Expenses	17,667		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due to / from Corporate</u>	(2,545,199)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 653,821	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,284,515		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,195,292		16
17	Accumulated Depreciation (book methods)	(3,305,862)		17
18	Deferred Charges	335,101		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):	571,510		22
23	Other(specify): <u>Goodwill</u>	559,027		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,177,583	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,831,404	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 163,021	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	100,205		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	313,380		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,900		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	39,625		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued HRA</u>	23,103		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 658,234	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,562,016		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,562,016	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,220,250	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,388,846)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,831,404	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,430,123)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,430,123)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,041,276	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,041,277	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,388,846)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/08Ending: 6/30/09

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,593,342	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,593,342	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	1,042,809	9
10	Other Government Grants	72,319	10
11	CNA Training Reimbursements	29,110	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	98,121	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,242,359	23
D. Non-Operating Revenue			
24	Contributions	9,734	24
25	Interest and Other Investment Income***	28,825	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,559	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,509,077	28
28a	<u>Miscellaneous Income</u>	2,021	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,511,098	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,385,358	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,131,445	31
32	Health Care	3,572,752	32
33	General Administration	2,074,252	33
B. Capital Expense			
34	Ownership	727,958	34
C. Ancillary Expense			
35	Special Cost Centers	1,434,876	35
36	Provider Participation Fee	402,801	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	(2)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,344,082	40
41	Income before Income Taxes (line 30 minus line 40)**	1,041,276	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,041,276	43

* 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 Swann Special Care Center

0035485

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	827	1,208	\$ 39,374	\$ 32.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,905	36,009	946,392	26.28	3
4	Licensed Practical Nurses	10,100	10,787	213,676	19.81	4
5	CNAs & Orderlies	112,624	121,803	1,463,716	12.02	5
6	CNA Trainees					6
7	Licensed Therapist	5,074	5,223	59,823	11.45	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	2,070	35,698	17.25	9
10	Activity Assistants	16,850	18,142	156,405	8.62	10
11	Social Service Workers	59	59	2,655	45.00	11
12	Dietician	208	208	3,571	17.17	12
13	Food Service Supervisor	1,915	2,094	43,520	20.78	13
14	Head Cook	13,542	14,565	183,778	12.62	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,832	4,302	58,165	13.52	17
18	Housekeepers					18
19	Laundry	1,989	2,188	33,820	15.46	19
20	Administrator	1,475	2,086	75,860	36.37	20
21	Assistant Administrator					21
22	Other Administrative	4,266	4,564	59,794	13.10	22
23	Office Manager					23
24	Clerical	6,003	6,687	119,089	17.81	24
25	Vocational Instruction					25
26	Academic Instruction	29,423	32,483	486,608	14.98	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Ward Clerk	1,978	2,098	22,779	10.86	32
33	Other(specify) Day Training	51,896	55,544	620,882	11.18	33
34	TOTAL (lines 1 - 33)	297,804	322,120	\$ 4,625,605 *	\$ 14.36	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	397	\$ 16,290	1.3	35
36	Medical Director	N/A	36,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	N/A	1,800	10.3	38
39	Pharmacist Consultant	N/A	975	10.3	39
40	Physical Therapy Consultant	20	5,393	10A.3	40
41	Occupational Therapy Consultant	1,064	61,795	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,095	72,243	10A.3	43
44	Activity Consultant	8	1,277	11.3	44
45	Social Service Consultant	37	2,066	12.3	45
46	Other(specify) Dental Fees	N/A	5,676	10.3	46
47	Resident Transport	N/A	16,780	14.3	47
48	See Attached	N/A	356,666		48
49	TOTAL (lines 35 - 48)	2,621	\$ 576,961		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,327	\$ 90,990	10.3	50
51	Licensed Practical Nurses	455	13,909	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,782	\$ 104,899		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kathleen Baker	Administrator	0	\$ 75,860	Workers' Compensation Insurance	\$ 99,298	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(2,337)	Advertising: Employee Recruitment		
				FICA Taxes	354,977	Health Care Worker Background Check		
				Employee Health Insurance	231,104	(Indicate # of checks performed <u>38</u>)	600	
				Employee Meals		Illinois Health Care Assoc.	6,790	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	4,754	
				Employee Benefits - Other	26,383	Chamber of Commerce	215	
				Employee Benefits - Retirement Plan	5,204	National Notary Association	8	
				Corporate Allocation	13,380	Corporate Allocation	296	
						Other Fees	1,301	
						Less: Public Relations Expense	(2,443)	
						Non-allowable advertising	(215)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 728,009			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corporate Expense			\$ 240,589				Out-of-State Travel	\$ 315
							Non-Allowable	(315)
							In-State Travel	10,426
							Non-Allowable	(426)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 240,589				Seminar Expense	12,594
							Nurse Aide Training Reclass	(560)
							Corporate Allocation	275
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 710,014	TOTAL		\$	TOTAL	\$ 22,309

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/08

Ending: 6/30/09

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. See Schedule XIX, Section F
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,000 Line 10.2
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 402,801
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? Yes 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 72,319
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
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? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 47,012
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.