

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 _____

	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	123	Skilled Pediatric (SNF/PED)	123	44,895	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	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					8
9	SNF/PED	40,552	377	8	40,937	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,552	377	8	40,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.18%

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

32 (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 08/15/1989

J. Was the facility purchased or leased after January 1, 1978?

YES Date 08/15/1989 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: FYE 6/30/2015 Fiscal Year: FYE 6/30/2015

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

Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	243,236	14,567	32,689	290,492		290,492	(81,179)	209,313		1
2	Food Purchase		206,668		206,668		206,668	(57,754)	148,914		2
3	Housekeeping		48,141	142,433	190,574		190,574	(56,416)	134,158		3
4	Laundry	18,650	7,705	101,420	127,775		127,775	(40,767)	87,008		4
5	Heat and Other Utilities			83,103	83,103		83,103	(7,086)	76,017		5
6	Maintenance	77,905	7,066	41,481	126,452	504	126,956	(204)	126,752		6
7	Other (specify):*										7
8	TOTAL General Services	339,791	284,147	401,126	1,025,064	504	1,025,568	(243,406)	782,162		8
	B. Health Care and Programs										
9	Medical Director			45,600	45,600		45,600		45,600		9
10	Nursing and Medical Records	2,894,855	312,781	22,810	3,230,446		3,230,446	(280,281)	2,950,165		10
10a	Therapy		49,027	148,467	197,494		197,494	(22,417)	175,077		10a
11	Activities	201,220	1,640		202,860		202,860		202,860		11
12	Social Services			1,482	1,482		1,482	(220)	1,262		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,096,075	363,448	218,359	3,677,882		3,677,882	(302,918)	3,374,964		16
	C. General Administration										
17	Administrative	96,056		154,596	250,652	274,515	525,167	(137,619)	387,548		17
18	Directors Fees										18
19	Professional Services			770,425	770,425	(452,185)	318,240	(238,864)	79,376		19
20	Dues, Fees, Subscriptions & Promotions			57,592	57,592	28,087	85,679	(38,597)	47,082		20
21	Clerical & General Office Expenses	120,912	13,711	77,594	212,217	27,216	239,433	(96,670)	142,763		21
22	Employee Benefits & Payroll Taxes			802,354	802,354	47,425	849,779	(188,341)	661,438		22
23	Inservice Training & Education			16,130	16,130	1,159	17,289	(6,391)	10,898		23
24	Travel and Seminar			7,149	7,149	40,303	47,452	(8,566)	38,886		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			23,957	23,957	4,437	28,394	19,331	47,725		26
27	Other (specify):* Indigent Care			11,399	11,399		11,399	(11,399)			27
28	TOTAL General Administration	216,968	13,711	1,921,196	2,151,875	(29,043)	2,122,832	(707,116)	1,415,716		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,652,834	661,306	2,540,681	6,854,821	(28,539)	6,826,282	(1,253,440)	5,572,842		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:

07/01/2014

Ending:

06/30/2015

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					8,090	8,090	139,189	147,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					5,530	5,530	207,854	213,384			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			616,090	616,090	14,063	630,153	(621,783)	8,370			34
35	Rent-Equipment & Vehicles			12,628	12,628	856	13,484	(347)	13,137			35
36	Other (specify):*							39,931	39,931			36
37	TOTAL Ownership			628,718	628,718	28,539	657,257	(235,156)	422,101			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,247,025	7,291	474,546	1,728,862		1,728,862	(1,696,969)	31,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			441,560	441,560		441,560		441,560			42
43	Other (specify):* Radiology			130	130		130		130			43
44	TOTAL Special Cost Centers	1,247,025	7,291	916,236	2,170,552		2,170,552	(1,696,969)	473,583			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,899,859	668,597	4,085,635	9,654,091		9,654,091	(3,185,565)	6,468,526			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

STATE OF ILLINOIS

#0035485

Report Period Beginning:

07/01/2014

Ending:

Swann Special Care Center
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION	INCREASE / (DECREASE)	SCH V LINE.COL
<u>1 Reclassification of Hoosier Care Group Expenses:</u>		
Administrative (Rel. Party Group Expense Allocation)	(125,508)	17.5
Administration	94,719	17.5
Dues, Fees, Subscriptions & Promotions	25,195	20.5
Clerical & General Office Expenses	64	21.5
Interest	5,530	32.5
<u>2 Reclassification of ELC Corporate Expenses</u>		
Professional Services (Rel. Party Mgmt. Fee)	(474,774)	19.5
Maintenance	504	6.5
Administrative	305,304	17.5
Professional Services	22,589	19.5
Dues, Fees, Subscriptions & Promotions	2,892	20.5
Clerical & General Office Expenses	27,152	21.5
Employee Benefits & Payroll Taxes	47,425	22.5
Inservice Training & Education	1,159	23.5
Travel & Seminar	40,303	24.5
Insurance - Prop.Liab.Malpractice	4,437	26.5
Depreciation	8,090	30.5
Rent - Facility & Grounds	14,063	34.5
Rent - Equipment	856	35.5

	Purpose of Seminar	Name of Attendee	Title of Attendee	Exp Amount
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for July - September			2,996
A	Champaign Co. Chamber of Commerce Business Success & Solutions Seminar - Telephone Etiquette	Ashley Peete	Business Office	17
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		315
A	Jeff Vose, Sangamon County ROE Illinois State Board of Education Conference	John Lawrence	Education - Teachers	150
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		315
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		280
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for October - December			2,996
A	Suburban Law Enforcement Adademy Criminal History Record Information Training Symposium	Ashley Peete	Business Office	30
A	Consultancy on International Education CIE Educational Advisory Service	Ashley Peete	Business Office	210
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		325
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		350

	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		910
A	Safe Food Handlers Corporation CLASS: Comprehensive Food Safety Course	Edwinn Rosal	Cook	150
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		245
	In-Pulse CPR Training and Certification CPR/AED training and certification	Various Employees		385
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for January - March			3,086
	IL Health Care Association ID/DD Symposium 2015	Kimberly Halberstadt	Executive Director	125
	IL Health Care Association WEB SEMINAR: POLST is More Than a Form It's a Process	Kimberly Halberstadt	Executive Director	75
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June			3,086
A	Allocated Regional Support Costs			177
A	Credits received from vendors			(93)
Line 23 Column 4 Total:				16,130
Line 23 Column 5 Reclassification - Corporate/Home Office Allocated Costs:				1,159
Line 23 Column 6 Total:				17,289

Unallowable Amounts above removed through SCH 5 Adjustments:

A Non-care related amounts noted above:

Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)

(641)

(5,750)

Line 23 Column 8 Total:

10,898

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	(1,696,969)	39		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,086)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	286	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,866)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,399)	27		24
25	Fund Raising, Advertising and Promotional	(27,966)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,068,313)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,814,313)		\$	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	(371,252)	17, 19	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (371,252)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,185,565)		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						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		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: 07/01/2014

Ending: 06/30/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Contributions Received Offset	\$ (28,382)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(73,147)	30	2
3	Unallowable Portion of Inservice Training/Edu	(641)	23	3
4	Unallowable Lobbying Portion of ILHCA Dues	(2,660)	20	4
5	Unallowable Portion of Travel/Seminar	(1,543)	24	5
6	Misc Income Offset	(918)	21	6
7				7
8				8
9				9
10	Unallowable Day Trng & EDU Alloc - Dietary	(81,179)	1	10
11	Unallowable Day Trng & EDU Alloc - Food	(57,754)	2	11
12	Unallowable Day Trng & EDU Alloc - Hskpg	(56,416)	3	12
13	Unallowable Day Trng & EDU Alloc - Laundry	(40,767)	4	13
14	Unallowable Day Trng & EDU Alloc - Maint	(204)	6	14
15	Unallowable Day Trng & EDU Alloc - Nursing	(280,281)	10	15
16	Unallowable Day Trng & EDU Alloc - Therapy	(22,417)	10a	16
17	Unallowable Day Trng & EDU Alloc - Soc Svcs	(220)	12	17
18	Unallowable Day Trng & EDU Alloc - Admin	(108,531)	17	18
19	Unallowable Day Trng & EDU Alloc - Prof Svcs	(13,465)	19	19
20	Unallowable Day Trng & EDU Alloc - Dues/Fees	(8,257)	20	20
21	Unallowable Day Trng & EDU Alloc - Clerical	(67,370)	21	21
22	Unallowable Day Trng & EDU Alloc - EE Ben/PR Tax	(188,341)	22	22
23	Unallowable Day Trng & EDU Alloc - Insrv/Training	(5,750)	23	23
24	Unallowable Day Trng & EDU Alloc - Travel/Seminar	(7,023)	24	24
25	Unallowable Day Trng & EDU Alloc - Insur	(11,493)	26	25
26	Unallowable Day Trng & EDU Alloc - Depr	(3,275)	30	26
27	Unallowable Day Trng & EDU Alloc - Interest	(2,239)	32	27
28	Unallowable Day Trng & EDU Alloc - Rent - buildings	(5,693)	34	28
29	Unallowable Day Trng & EDU Alloc - Rent - equip	(347)	35	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	Total	(1,068,313)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(81,179)	0	0	0	0	0	0	0	0	0	0	(81,179)	1
2	Food Purchase	(57,754)	0	0	0	0	0	0	0	0	0	0	(57,754)	2
3	Housekeeping	(56,416)	0	0	0	0	0	0	0	0	0	0	(56,416)	3
4	Laundry	(40,767)	0	0	0	0	0	0	0	0	0	0	(40,767)	4
5	Heat and Other Utilities	(7,086)	0	0	0	0	0	0	0	0	0	0	(7,086)	5
6	Maintenance	(204)	0	0	0	0	0	0	0	0	0	0	(204)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(243,406)	0	0	0	0	0	0	0	0	0	0	(243,406)	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	(280,281)	0	0	0	0	0	0	0	0	0	0	(280,281)	10
10a	Therapy	(22,417)	0	0	0	0	0	0	0	0	0	0	(22,417)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(220)	0	0	0	0	0	0	0	0	0	0	(220)	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	(302,918)	0	0	0	0	0	0	0	0	0	0	(302,918)	16
	C. General Administration													
17	Administrative	(108,531)	(29,088)	0	0	0	0	0	0	0	0	0	(137,619)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,331)	(234,426)	11,893	0	0	0	0	0	0	0	0	(238,864)	19
20	Fees, Subscriptions & Promotions	(38,597)	0	0	0	0	0	0	0	0	0	0	(38,597)	20
21	Clerical & General Office Expenses	(96,670)	0	0	0	0	0	0	0	0	0	0	(96,670)	21
22	Employee Benefits & Payroll Taxes	(188,341)	0	0	0	0	0	0	0	0	0	0	(188,341)	22
23	Inservice Training & Education	(6,391)	0	0	0	0	0	0	0	0	0	0	(6,391)	23
24	Travel and Seminar	(8,566)	0	0	0	0	0	0	0	0	0	0	(8,566)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(11,493)	0	30,824	0	0	0	0	0	0	0	0	19,331	26
27	Other (specify):*	(11,399)	0	0	0	0	0	0	0	0	0	0	(11,399)	27
28	TOTAL General Administration	(486,319)	(263,514)	42,717	0	(707,116)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,032,643)	(263,514)	42,717	0	(1,253,440)	29							

STATE OF ILLINOIS

Facility Name & ID Number Swann Special Care Center# 0035485

Report Period Beginning:

07/01/2014 Ending:

Summary B

06/30/2015

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	(76,422)	0	215,611	0	0	0	0	0	0	0	0	139,189	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,239)	0	210,093	0	0	0	0	0	0	0	0	207,854	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(5,693)	0	(616,090)	0	0	0	0	0	0	0	0	(621,783)	34
35	Rent-Equipment & Vehicles	(347)	0	0	0	0	0	0	0	0	0	0	(347)	35
36	Other (specify):*	0	0	39,931	0	0	0	0	0	0	0	0	39,931	36
37	TOTAL Ownership	(84,701)	0	(150,455)	0	(235,156)	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	(1,696,969)	0	0	0	0	0	0	0	0	0	0	(1,696,969)	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	(1,696,969)	0	0	0	0	0	0	0	0	0	0	(1,696,969)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,814,313)	(263,514)	(107,738)	0	0	0	0	0	0	0	0	(3,185,565)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Hoosier Care, Inc.	100	Exceptional Care & Training Center	Sterling, IL	Medical Rehabilitation	Lexington, KY	Mgmt Co.
		Walter Lawson Children's Home	Loves Park, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Vernon Manor Children's Home	Wabash, IN	Campaign Facility Co	Champaign, IL	Property Co.
		Richland-Bean Blossom Health Care Center	Ellettsville, IN			
		Exceptional Living Centers of Brazil	Brazil, IN			
		Randolph Nursing Home	Winchester, IN			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
1	V	17 Corporate Group Overhead	\$ 154,596	Hoosier Care, Inc.	100.00%	\$ 125,508	\$	(29,088)	1	
2	V			Note: See Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Schedule V.					2	
3	V								3	
4	V								4	
5	V	19 Rel. Party Management Fee	709,200	Medical Rehabilitation Centers, LLC	37.50%	474,774		(234,426)	5	
6	V			dba Exceptional Living Centers					6	
7	V			Hoosier Care owns a beneficial interest in MRC					7	
8	V			Note: Please see Schedule VIII for Allocation of Col. 7 amt and reclassification to functional expense lines on Sch V.					8	
9	V								9	
10	V								10	
11	V	PLEASE SEE DISCLOSURE AND DETAIL OF ADJUSTMENTS CONTINUED ON THE NEXT PAGE (6A):								11
12	V								12	
13	V								13	
14	Total		\$ 863,796			\$ 600,282	\$ *	(263,514)	14	

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rel. Party Bldg/Equip Rent	\$ 616,090	Champaign Facility Company, LLC	100.00%	\$	\$ (616,090)
16	V			This facility company is under 100% common			
17	V			ownership with SSCC, and therefore the "rent" paid			
18	V			to the facility company has been removed from this report,			
19	V			and the actual expenses of the facility company have been			
20	V			added here:			
21	V	30 Actual Depreciation of Rel Pty		-Depreciation		215,611	215,611
22	V	32 Actual Interest of Rel Pty		-Interest (net of interest income)		202,706	202,706
23	V	32 Actual Amort of Debt Cost-Rel Pty		-Amort of Debt Costs		7,387	7,387
24	V	26 Actual Insurance of Rel Pty		-Insurance		30,824	30,824
25	V	36 Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		39,931	39,931
26	V	19 Actual Accting Fees of Rel Pty		-Accounting Fees		11,893	11,893
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 616,090			\$ 508,352	\$ * (107,738)

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	John Foos	Board Member	Governance	0%					\$	1
2	John Gillmor	Board Member	Governance	0%						2
3	Bruce Hutson	Board Member	Governance	0%						3
4	Jo Anne Corbitt	Board Member	Governance	0%						4
5	Douglas Smith	Board Member	Governance	0%						5
6	Stephen Wood	Board Member	Governance	0%						6
7	NOTE: Fees are paid by SSCC (through the Hoosier Care, Inc. group/home cost center detailed on Pg 8) to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-p									7
8	which go toward, among other things solely within the control of HCI, fees for members of the Boards of Directors of HCI affiliated facilities, Swann Special									8
9	Care Center being one of many. Therefore no Board Fees or compensation are paid directly by, or known to SSCC, but rather the fees paid by HoosierCare to HCI are									9
10	combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight, including payment by HCI to Board members of each legal									10
11	entity. Fees paid by other facilities, if known, are shown on Page 7.1; The entire amount of fees included on this report, grouped on Line 17, is disclosed here:									11
12								ADMIN FEES	94,719	17.8
13								TOTAL	\$ 94,719	

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

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

VII. RELATED PARTIES (continued)

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

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

Amounts paid for Home Office Administration Fees by other Nursing Homes

Walter Lawson Children's Home	77,783	Illinois
Swann Special Care Center	94,719	Illinois
Exceptional Care & Training Center	58,852	Illinois
Vernon Manor Children's Home	56,879	Indiana
Exceptional Living Center of Brazil	70,405	Indiana
Richland-Bean Blossom Health Care	54,005	Indiana
Randolph Nursing Home	52,856	Indiana

Net allowable Related Party Management Fees paid by other Nursing Homes

Walter Lawson Children's Home	389,883	Illinois
Swann Special Care Center	474,774	Illinois
Exceptional Care & Training Center	294,989	Illinois
Vernon Manor Children's Home	285,100	Indiana
Exceptional Living Center of Brazil	352,897	Indiana
Richland-Bean Blossom Health Care	270,693	Indiana
Randolph Nursing Home	264,935	Indiana

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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 Hoosier Care, Inc.
 Street Address 1050 Chinoe Road, Suite 350
 City / State / Zip Code Lexington, KY 40502
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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	17	Administrative	Direct Cost	42,718,084	7	\$ 465,498	\$ 0	8,692,272	\$ 94,719	1
2	20	Dues, Fees, Subscriptions & Prom	Direct Cost	42,718,084	7	123,820	0	8,692,272	25,195	2
3	21	Clerical & General Office Expens	Direct Cost	42,718,084	7	316	0	8,692,272	64	3
4	32	Interest	Direct Cost	42,718,084	7	27,175	0	8,692,272	5,530	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 616,809	\$		\$ 125,508	25

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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 Medical Rehabilitation Centers, LLC, dba Except
 Street Address 1050 Chinoe Road, Suite 350
 City / State / Zip Code Lexington, KY 40502
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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	6	Maintenance	Direct Costs	15	\$ 4,803	\$	8,692,272	\$ 504	1
2	17	Administrative	Direct Costs	15	2,909,082	2,849,135	8,692,272	305,304	2
3	19	Professional Services	Direct Costs	15	215,236		8,692,272	22,589	3
4	20	Dues, Fees, Subscriptions	Direct Costs	15	27,556		8,692,272	2,892	4
5	21	Clerical & General Office	Direct Costs	15	258,716		8,692,272	27,152	5
6	22	Employee Benefits & Payroll Tax	Direct Costs	15	451,890		8,692,272	47,425	6
7	23	Inservice Training & Education	Direct Costs	15	11,045		8,692,272	1,159	7
8	24	Travel & Seminar	Direct Costs	15	384,026		8,692,272	40,303	8
9	26	Insurance	Direct Costs	15	42,282		8,692,272	4,437	9
10	30	Depreciation	Direct Costs	15	77,083		8,692,272	8,090	10
11	32	Interest	Direct Costs	15			8,692,272		11
12	34	Rent - Facility & Grounds	Direct Costs	15	133,999		8,692,272	14,063	12
13	35	Rent - Equipment	Direct Costs	15	8,152		8,692,272	856	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				\$ 4,523,870	\$ 2,849,135		\$ 474,774	25

Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	LP Mortgage HUD Loan		X	Facility Purchase Financing	\$33,276.00	11/1/12	\$ 8,377,500	\$ 7,896,600	11/1/42	0.0254	\$ 202,866						
2																	
3																	
4																	
5																	
Working Capital																	
6	GE Healthcare Finance		X	Working Capital		10/27/11	5,000,000		10/27/14	Variable							
7	GE Healthcare Finance		X	Working Capital		06/24/14	5,750,000		10/27/19	Variable							
8																	
9	TOTAL Facility Related				\$33,276.00		\$ 19,127,500	\$ 7,896,600			\$ 202,866						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 19,127,500	\$ 7,896,600			\$ 202,866						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,931 Line # 36

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

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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>TAX EXEMPT</u>	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

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).

Swann School Education Program, operated offsite; cost removal adjustments & allocation to remove associated costs shown on SCH V and further explanation on Pg 11.

Swann Developmental Day Training Program, operated offsite; cost removal adjustments & allocation to remove associated costs shown on SCH V and further explanation on Pg 11.

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>SNF / PED</u>	<u>89,603</u>	<u>1989</u>	<u>\$ 538,000</u>	1
2					2
3	TOTALS	89,603		\$ 538,000	3

Swann Special Care Center

Schedule X Supplemental Schedule

Item 14 - Allocation of non-long term care costs

- (E) Swann Special Care Center operates Education and Developmental Day Training programs in dedicated spaces offsite from the skilled nursing facility. All costs specifically attributable to these programs in dedicated GL accounts, including wages/salaries, supplies, rent and occupancy costs, have been grouped in line 39 of Schedule V, "Ancillary Service Centers", and are removed via adjustment on Schedule VI, Line 3. In addition, a portion of all other cost centers and expense items which provide benefits and support to the Education and Day Training programs are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

Costs incurred which benefit multiple operational programs are identified, segregated, and reported each year in conjunction with required cost report filings to the Illinois Purchased Care Review Board for the Educational program. The percentage of costs identified for each program from the most recent ILPCRB report are utilized to calculate the portion attributable to Day Training and Education which is removed in this Cost Report. A percentage of wages and salaries expense, identifiable to each specific program and position, is utilized to allocate Employee benefits and payroll taxes. Hours of operation of each program are utilized to allocate certain administrative, overhead, and support services, and other allocation bases are utilized for applicable shared costs.

The results of these allocations appear on Schedule VI, as adjustments to remove shared costs attributable to non-long term care services.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	87	1989	1978	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,799,460	4
5	9		1993	N/A						5
6	8		1996	N/A						6
7	8		2000	N/A						7
8	11		2004	N/A						8
Improvement Type**										
9	FIRE DOORS		7/16/1990	2,751.00	-	10-0			2,751.00	9
10	STORM WINDOW		6/17/1991	4,224.50	-	10-0			4,224.50	10
11	FIRE DOORS		6/20/1991	3,675.00	-	10-0			3,675.00	11
12	SPRINKLER/EXIT DEVICES OD		1/30/1992	3,162.00	-	10-0			3,162.00	12
13	ROOFING		12/4/1992	3,900.00	-	10-0			3,900.00	13
14	SPRINKLER SYSTEM		3/30/1993	14,460.00	-	10-0			14,460.00	14
15	WALL COVERING		5/20/1993	3,190.36	-	10-0			3,190.36	15
16	WALL PAPERING		6/28/1993	3,000.00	-	10-0			3,000.00	16
17	CARPET AND RUBBER BASE		7/23/1993	2,848.00	-	10-0			2,848.00	17
18	FIRE DOORS, CLOSETS, TILE		11/1/1993	5,225.00	-	10-0			5,225.00	18
19	MATERIALS FOR LEASEHOLD I		2/1/1995	7,858.06	-	3-0			7,858.06	19
20	HOODS, FANS, ANSUL SYSTEM		3/14/1995	2,500.00	-	10-0			2,500.00	20
21	WORK FOR EXHAUST FAN & HO		4/6/1995	3,995.00	-	10-0			3,995.00	21
22	REPLACE WATER HEATER		6/15/1995	3,750.00	-	10-0			3,750.00	22
23	WALK-IN COOLER		10/24/1995	3,333.55	-	10-0			3,333.55	23
24	CONSTRUCT SHELVING,BEDS,S		12/18/1996	2,964.00	-	3-0			2,964.00	24
25	REPLACE 2 ROOFTOP HVAC UN		12/7/1998	17,650.00	-	10-0			17,650.00	25
26	REMOVE/RPLCE HOT WATER HE		5/25/1999	3,000.00	-	10-0			3,000.00	26
27	REPLACE RELAY ON GENERATO		10/5/1999	2,782.29	-	10-0			2,782.29	27
28	BALANCE-INSTALL ALARM SYS		6/29/2000	2,730.00	-	5-0			2,730.00	28
29	INSTALL CLINICAL SINK.		7/18/2000	3,030.00	-	5-0			3,030.00	29
30	INSTALL DOORS AT KENWOOD		7/18/2000	4,028.41	268.56	15-0	269		4,028.40	30
31	REPLACE GATE VALVE/INSTAL		9/8/2000	6,005.22	400.35	15-0	400		5,938.44	31
32	NEW FLOOR DRAINS IN SHOWE		1/24/2001	3,180.00	212.00	15-0	212		3,074.10	32
33	INSTALL SHOWER DRAINS		7/16/2001	10,500.00	525.00	20-0	525		7,350.00	33
34	REPLACE DOORS		1/2/2002	3,000.00	-	5-0			3,000.00	34
35	SECURITY SYSTEM		2/21/2002	3,165.00	-	5-0			3,165.00	35
36	INTERNET SET-UP-WIRING, C		2/21/2002	6,140.86	409.39	15-0	409		5,492.72	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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL TWO SINKS	5/13/2002	\$ 3,561.00	\$ -	5-0	\$	\$	\$ 3,561.00	37
38	CARPET AND INSTALLATION	7/16/2002	2,954.00	-	10-0			2,954.00	38
39	INSTALL A/C ROOFTOP UNIT	8/26/2002	8,237.31	549.15	15-0	549		7,093.16	39
40	INSTALLED NEW PHONE SYS.S	10/15/2002	2,735.00	-	5-0			2,735.00	40
41	HEIGHT ADJ.SUPINE TUB	12/16/2002	8,469.14	-	10-0			8,469.14	41
42	CENTRAL HEAT/AIR ROOFTOP	1/22/2003	5,180.00	345.33	15-0	345		4,316.64	42
43	ELECTRIC WATER HEATER	3/17/2003	5,600.00	-	10-0			5,600.00	43
44	Rooftop unit installed; heat/air wing 3	7/31/2003	10,910.00	727.33	15-0	727		8,667.35	44
45	roofing project-Wing 1,2,4 (23318.33+431	6/8/2005	66,485.00	4,432.33	15-0	4,432		44,692.66	45
46	Re-tile shower room	4/27/2006	10,714.00	714.27	15-0	714		6,547.47	46
47	Deposit for duro last roof	7/13/2006	10,000.00	666.67	15-0	667		6,000.03	47
48	Duro last roof - payment #2	7/13/2006	4,383.92	292.26	15-0	292		2,630.34	48
49	100 amp sub panel	9/25/2006	2,649.59	176.64	15-0	177		1,545.60	49
50	Re-tile shower room #10	9/27/2006	11,642.00	776.13	15-0	776		6,791.14	50
51	Replace walls in dishwasher area	12/5/2006	7,477.26	498.48	15-0	498		4,278.62	51
52	Re-tile shower room #3	12/15/2006	11,642.00	776.13	15-0	776		6,661.78	52
53	Re-tile shower room #4	12/28/2006	11,642.00	776.13	15-0	776		6,597.11	53
54	Re-tile shower room #s 5,6,7	3/15/2007	12,746.00	849.73	15-0	850		7,081.08	54
55	Rpl motors on roof exhaust fans (7)	8/7/2007	2,667.17	266.72	10-0	267		2,111.53	55
56	Upgrade lighting system in education bld	8/21/2007	6,501.38	433.43	15-0	433		3,395.20	56
57	Re-tile team 6 bathroom	8/29/2007	7,560.92	504.06	15-0	504		3,948.47	57
58	Wire breakroom & outlets for nurses stat	12/4/2007	2,574.32	171.62	15-0	172		1,301.45	58
59	Replace 2 doors in laundry area	2/29/2008	4,187.00	279.13	15-0	279		2,046.95	59
60	Remodel conf room (cabinets, counter, c-	7/10/2008	2,536.02	253.60	10-0	254		1,775.20	60
61	Addnl outlets (4 ea.) in rooms 5,6,8,9,	12/4/2008	7,625.00	508.33	15-0	508		3,346.51	61
62	Compressor for a/c unit	9/11/2009	2,830.00	283.00	10-0	283		1,650.83	62
63	Induct air purifiers (8) and required el	12/14/2009	3,637.79	363.78	10-0	364		2,031.10	63
64	Outlets (24) in resident rooms	10/9/2010	12,618.04	841.20	15-0	841		3,995.70	64
65	Outlets in rooms 3b/1b/5a/6a/5b/6b	12/16/2010	8,280.00	552.00	15-0	552		2,484.00	65
66	Outlets in rooms 7a/7b/13/14/17/11b/12a/	1/24/2011	13,800.00	920.00	15-0	920		4,063.33	66
67	Compressor & blower wheel	6/28/2011	2,575.00	257.50	10-0	258		1,030.00	67
68	Sprinklers for ext eaves on west wing	9/20/2011	4,275.00	427.50	10-0	428		1,603.13	68
69	Tile floor & walls of bathrooms (3)	11/29/2011	19,853.80	1,323.59	15-0	1,324		4,742.86	69
70	TOTAL (lines 4 thru 69)		\$ 3,026,598	\$ 77,056		\$ 77,056	\$	\$ 2,107,286	70

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

Facility Name & ID Number Swann Special Care Center

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 3,026,598	\$ 77,056		\$ 77,056		\$ 2,107,286		1
2	Heat exchanger	12/12/2011 4,035.00	403.50	10-0	404		1,445.88		2
3	Network drops (32) for Paige II	12/13/2011 2,550.00	255.00	10-0	255		913.75		3
4	Heat exchanger	3/16/2012 6,570.00	657.00	10-0	657		2,135.25		4
5	Renovate shower rooms #2/14/15	4/23/2012 19,500.00	1,300.00	15-0	1,300		4,116.67		5
6	Weatherization project	7/1/2012 3,099.00	309.90	10-0	310		929.70		6
7	Flooring for shower room	10/18/2012 6,000.00	600.00	10-0	600		1,600.00		7
8	Exterior painting & waterproofing	10/26/2012 9,752.00	650.13	15-0	650		1,733.68		8
9	Emergency generator	2/28/2013 63,610.00	4,240.67	15-0	4,241		9,894.90		9
10	IDPH Electrical Work(Project:Swann Gener	5/1/2013 32,000.00	2,133.33	15-0	2,133		4,622.22		10
11	New Flooring Installed	5/1/2013 6,132.50	408.83	15-0	409		885.80		11
12	New Flooring Installed - 3rd Shower	5/13/2013 6,000.00	400.00	15-0	400		866.67		12
13	IDPH Electrical Work(Project:Swann Gener	6/25/2013 17,855.00	1,190.33	15-0	1,190		2,380.66		13
14	Drain Tile Installation	10/23/2013 11,896.63	1,189.66	10-0	1,190		1,982.77		14
15	Security System for Front Door	3/5/2014 3,547.00	354.70	10-0	355		472.93		15
16	Mop Room Renovation	4/14/2014 3,520.00	352.00	10-0	352		440.00		16
17	Mop Room Renovation	4/15/2014 4,635.75	463.58	10-0	464		579.47		17
18	TheraPure Tub	8/26/2014 12,038.12	1,003.18	10-0	1,003		1,003.18		18
19	Whirlpool Room Flooring	8/27/2014 4,300.00	358.33	10-0	358		358.33		19
20	Team 8 Shower Room Flooring	2/17/2015 7,600.00	253.33	10-0	253		253.33		20
21	RESURFACE PARKING LOT	11/1/1993 19,115.00	-	10-0			19,115.00		21
22	REPLACE UNDERGROUND FUEL	11/11/1998 9,223.00	461.15	20-0	461		7,685.88		22
23	RE-SEAL AND RE-STRIPE PAR	7/1/2002 2,810.00	-	10-0			2,810.00		23
24	Install draining system in courtyard	2/2/2004 9,267.57	-	7-0			9,267.57		24
25	Parking lot/dumpster pad repaved	10/20/2006 8,073.00	807.30	10-0	807		6,996.60		25
26	Fence/dumpster enclosure	12/16/2006 2,750.00	275.00	10-0	275		2,337.50		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,302,477	\$ 95,123		\$ 95,123		\$ 2,192,114		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 158,185	\$ 30,017	\$ 30,017	\$	3-10	\$ 106,192	71
72	Current Year Purchases	32,058	2,973	2,973		5-7	2,973	72
73	Fully Depreciated Assets	771,293	14,350	14,350		3-10	771,293	73
74	Depr Exp (Net Allowable) - Rel Pty Alloc Sch VIII		4,816	4,816				74
75	TOTALS	\$ 961,536	\$ 52,156	\$ 52,156	\$		\$ 880,458	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 4,802,013	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,279	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)	\$ 3,072,572	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Transportation Equip Not Allowed	\$ 180,325	\$ 11,556	\$ 167,765	86
87	Assets below IL Capital Threshold	563,728	28,423	459,496	87
88	Assets Disallowed by DHS Cap Review	1,156,556	33,168	878,183	88
89					89
90					90
91	TOTALS	\$ 1,900,609	\$ 73,147	\$ 1,505,444	91

G. Construction-in-Progress

	Description	Cost	
92	Matrix Implementation	\$ 815	92
93	Facility Addition	46,196	93
94			94
95		\$ 47,011	95

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

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - Facility Leased from 100% Commonly-owned Related Party (See Sch VII)

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

If NO, see instructions. 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	Corp Group Office Allocation		N/A	12/1/2011	14,063	10	10	5
6								6
7	TOTAL				\$ 14,063			7

10. Effective dates of current rental agreement:

Beginning 12/1/2011

Ending 12/1/2021

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 6/30/2016 \$ Corp Alloc Amt

13. 6/30/2017 \$ Corp Alloc Amt

14. 6/30/2018 \$ Corp Alloc Amt

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: \$ 13,484 Description: Copy/Scanners: \$5,239; Postage Meter: \$2,360; Short Term Medical Equip: \$5,029; Corp Alloc: \$856

(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

* 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: 07/01/2014 Ending: 06/30/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Aides are either non-certified, hired with certification, or become certified as D.S.P.s rather than CNAs</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	1,380	\$ 66,893	\$	1,380	\$ 66,893	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,053	73,710		1,053	73,710	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		130	6,475		130	6,475	4
5	Physician Care	39.3	visits			9,600			9,600	5
6	Dental Care	39.3	visits		154	6,170		154	6,170	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		127	8,282		127	8,282	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs		12	1,060		12	1,060	10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10a.3			46	1,389		46	1,389	12
13	Other (specify): <u>Note: Line 5 Physician Care is flat fee Neurologist evals</u>									13
14	TOTAL			\$	2,902	\$ 173,579	\$	2,902	\$ 173,579	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

0035485

Report Period Beginning: 07/01/2014

Ending:

06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 86,564)	1,598,162	1,598,162	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,360	99,008	6
7	Other Prepaid Expenses	24,817	34,248	7
8	Accounts Receivable (owners or related parties)	4,051,513	4,049,362	8
9	Other(specify): <u>Rounding</u>		(1)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,759,352	\$ 5,781,679	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		4,610,709	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,553,914	16
17	Accumulated Depreciation (book methods)		(4,578,016)	17
18	Deferred Charges		202,042	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		227,367	21
22	Other Long-Term Assets (spe CIP)		47,011	22
23	Other(specify): <u>Goodwill</u>	531,191	531,191	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 531,191	\$ 3,132,218	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,290,543	\$ 8,913,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,408	\$ 222,408	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		201,065	29
30	Accrued Salaries Payable	398,697	398,697	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,000	17,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		16,714	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany/Due to Lessor</u>		109,540	36
37	<u>Rounding</u>		2	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 638,105	\$ 965,426	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,695,535	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,695,535	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 638,105	\$ 8,660,961	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,652,438	\$ 252,936	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,290,543	\$ 8,913,897	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,574,190	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,574,190	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	78,248	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 78,248	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)	\$ 5,652,438	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 07/01/2014Ending: 06/30/2015

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,041,431	1
2	Discounts and Allowances for all Levels	(1,296)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,040,135	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	826,915	9
10	Other Government Grants	58,911	10
11	CNA Training Reimbursements		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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 885,826	23
D. Non-Operating Revenue			
24	Contributions	28,382	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,382	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	(156)	27
28	Day Training	1,778,152	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,777,996	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,732,339	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,025,064	31
32	Health Care	3,677,882	32
33	General Administration	2,151,875	33
B. Capital Expense			
34	Ownership	628,718	34
C. Ancillary Expense			
35	Special Cost Centers	1,728,992	35
36	Provider Participation Fee	441,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,654,091	40
41	Income before Income Taxes (line 30 minus line 40)**	78,248	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 78,248	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,939,854	44
45	Private Pay - Net Inpatient Revenue	96,940	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice Revenue</u>	3,341	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,040,135	49

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

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

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

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2014

Ending:

06/30/2015

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	1,834	2,029	\$ 96,477	\$ 47.55	1
2	Assistant Director of Nursing	2,093	2,308	72,338	31.34	2
3	Registered Nurses	34,740	37,825	1,072,546	28.36	3
4	Licensed Practical Nurses	9,740	10,576	212,387	20.08	4
5	CNAs & Orderlies	95,741	104,000	1,349,594	12.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,837	6,327	70,373	11.12	8
9	Activity Director	1,851	2,102	43,286	20.59	9
10	Activity Assistants	15,059	16,348	157,934	9.66	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,918	2,162	53,295	24.65	13
14	Head Cook	13,105	14,292	189,942	13.29	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,991	4,494	77,905	17.34	17
18	Housekeepers					18
19	Laundry	1,941	2,068	18,650	9.02	19
20	Administrator	1,924	2,164	96,056	44.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,659	7,274	120,912	16.62	24
25	Vocational Instruction	74,513	82,208	1,182,316	14.38	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)	3,913	4,308	64,710	15.02	30
31	Medical Records					31
32	Other Health Care(specify)	1,761	1,889	21,141	11.19	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	276,620	302,374	\$ 4,899,862 *	\$ 16.20	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	422	\$ 17,578	1.3	35
36	Medical Director	N/A	45,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	N/A	22,211	10.3	38
39	Pharmacist Consultant				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	30	1,482	12.3	45
46	Other(specify)				46
47					47
48	Note: Medical Dir paid flat rate, not hourly				48
49	TOTAL (lines 35 - 48)	452	\$ 86,271		49

C. CONTRACT NURSES

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

Facility Name & ID Number

Swann Special Care Center

35485

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

Swann Special Care Center
Schedule XIX Supplemental Schedule
Legal Fees Detail

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/29/2014	Stoll-Keenon-Ogden PLLC	\$ 67.00
8/29/2014	Stoll-Keenon-Ogden PLLC	\$ 162.00
8/29/2014	Stoll-Keenon-Ogden PLLC	\$ 40.50
11/11/2014	Stoll-Keenon-Ogden PLLC	\$ 81.00
11/11/2014	Stoll-Keenon-Ogden PLLC	\$ 1,192.50
12/9/2014	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 252.00
12/9/2014	Stoll-Keenon-Ogden PLLC	\$ 13.50
12/15/2014	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 1,025.00
12/16/2014	Mary Ann Royse Law Office	\$ 498.75
1/27/2015	Mary Ann Royse Law Office	\$ 411.25
1/27/2015	SmithAmundsen	\$ 450.00
2/3/2015	Duane Morris LLP	\$ 21.83
2/10/2015	Stoll-Keenon-Ogden PLLC	\$ 13.50
3/24/2015	Mary Ann Royse Law Office	\$ 262.50
3/26/2015	Hinshaw & Culbertson,, LLP	\$ 12,291.18
12/19/2014	Hinshaw & Culbertson,, LLP	\$ (7,820.43)
4/21/2015	Duane Morris LLP	\$ 23.00
4/28/2015	Mary Ann Royse Law Office	\$ 621.25
5/8/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 189.00
5/19/2015	Mary Ann Royse Law Office	\$ 761.25
6/16/2015	Duane Morris LLP	\$ 22.67
6/16/2015	Stites&Harbison PLLC	\$ 139.33
6/30/2015	Mary Ann Royse Law Office	\$ 585.00
12/15/2014	DeWitt Ross & Stevens	\$ 38.97
5/29/2015	Stites&Harbison PLLC	\$ 106.00
5/29/2015	Stites&Harbison PLLC	\$ 253.33
7/31/2014	In-House Counsel Legal Fees	\$ 1,424.85
8/31/2014	In-House Counsel Legal Fees	\$ 1,525.60
9/30/2014	In-House Counsel Legal Fees	\$ 1,413.83
10/31/2014	In-House Counsel Legal Fees	\$ 975.31

11/30/2014 In-House Counsel Legal Fees	\$ 1,508.04
12/31/2014 In-House Counsel Legal Fees	\$ 1,152.43
1/31/2015 In-House Counsel Legal Fees	\$ 1,583.10
2/28/2015 In-House Counsel Legal Fees	\$ 1,426.80
3/31/2015 In-House Counsel Legal Fees	\$ 1,565.45
4/30/2015 In-House Counsel Legal Fees	\$ 1,045.70
5/31/2015 In-House Counsel Legal Fees	\$ 1,058.87
6/30/2015 In-House Counsel Legal Fees	\$ 1,103.07

\$ 27,484.93

See Schedule VI for adjustment for unallowable portion.

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Swann Special Care Center
Schedule XIX Supplemental Schedule
Travel & Seminar In-State detail:

DESCRIPTION	Amount	SCH V LINE.COL
1 In-State Travel Detail		
Armel Mallare, Day Training, in-state travel	128 A	24.3
Ashley Peete, care-related in-state travel	394	24.3
Debbie Meek, BoM, care-related in-state travel	264	24.3
Ferdinand Mendoza, Education, in-state travel	433 A	24.3
Gale Kirkpatrick, Maintenance, care-related in-state travel	497	24.3
John Lawrence, Education, special education conference	488 A	24.3
Kym Halberstadt, Exec Director, care-related in-state travel	642	24.3
Mary J. Ward, care-related in-state travel	90	24.3
Raymund Mangantulao, Day Training, resident appointments	424 A	24.3
Roseller Dimla, Health Unit Coord., resident appointments	66	24.3
Wynell Prince Eakle, C.B.O., in-state travel for training	1,042	24.3
In-state business meals	70 A	24.3
Corporate/Group travel allocation of operations personnel	1,916	24.3
	6,455	
1 Out-of-State Travel (All to Home Office or Care-related training) Detail		
Debbie Meek, BoM, care-related out-of-state travel	466	24.3
Kym Halberstadt, Exec Director, care-related out-of-state travel	227	24.3
	694	
Line 24 Column 4 Total:	7,149	(0)
Line 24 Column 5 Reclassification - Corporate/Home Office Allocated C	40,303	0
<i>Unallowable Amounts above removed through SCH 5 Adjustments:</i>		
A Non-care related amounts noted above:	(1,543)	
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(7,023)	
Line 24 Column 8 Total:	38,885	(0)

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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. ILHCA, \$4,474 net after Schedule VI Adj
- (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? _____
- (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? _____
- (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. \$ 103,185 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 441,560
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. \$ Non Has any meal income been offset against related costs? Yes Indicate the amount. \$ 58,911
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? See Pg 21.1
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe Horwath
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.