FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0032680

Facility Name: ROSEWOOD CARE CENTER SWANSEA

Address: 100 Rosewood Village Dr. (Number) Swansea (City) 62222 (Zip Code)

County: St. Clair

Telephone Number: (618) 236-1391 **Fax #** (618) 236-9622

HFS ID Number:

Date of Initial License for Current Owners: 10/8/1987

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/10 to 6/30/11 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,077	10,077	8
9	SNF/PED					9
10	ICF	2,858	24,027		26,885	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,858	24,027	10,077	36,962	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.39%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 10/8/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/8/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 10,077

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	214,578	22,672	17,001	254,251		254,251	(5,595)	248,656			1
2	Food Purchase		192,739		192,739		192,739	(10,932)	181,807			2
3	Housekeeping	165,612	33,111		198,723		198,723		198,723			3
4	Laundry	50,465	19,089		69,554		69,554		69,554			4
5	Heat and Other Utilities			152,143	152,143		152,143	309	152,452			5
6	Maintenance	29,733	10,406	992,046	1,032,185		1,032,185	(525,940)	506,245			6
7	Other (specify):* Garbage Collection			13,428	13,428		13,428		13,428			7
8	TOTAL General Services	460,388	278,017	1,174,618	1,913,023		1,913,023	(542,158)	1,370,865			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	2,264,100	187,093	24,368	2,475,561		2,475,561		2,475,561			10
10a	Therapy	114,314	8,635	849,711	972,660		972,660		972,660			10a
11	Activities	57,908	5,133	2,400	65,441		65,441		65,441			11
12	Social Services	62,078		2,400	64,478		64,478		64,478			12
13	CNA Training											13
14	Program Transportation			6	6		6		6			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,498,400	200,861	884,385	3,583,646		3,583,646		3,583,646			16
	C. General Administration											
17	Administrative	244,939		589,000	833,939		833,939	(320,883)	513,056			17
18	Directors Fees											18
19	Professional Services			322,271	322,271		322,271	(47,482)	274,789			19
20	Dues, Fees, Subscriptions & Promotions			24,789	24,789	1,445	26,234	(7,477)	18,757			20
21	Clerical & General Office Expenses	181,525	99,065	448,546	729,136		729,136	(335,143)	393,993			21
22	Employee Benefits & Payroll Taxes			476,916	476,916		476,916	35,384	512,300			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,228	2,228	(1,445)	783	4,947	5,730			24
25	Other Admin. Staff Transportation			6,414	6,414		6,414	2,573	8,987			25
26	Insurance-Prop.Liab.Malpractice			270,064	270,064		270,064	4,510	274,574			26
27	Other (specify):*											27
28	TOTAL General Administration	426,464	99,065	2,140,228	2,665,757		2,665,757	(663,571)	2,002,186			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,385,252	577,943	4,199,231	8,162,426		8,162,426	(1,205,729)	6,956,697			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 ROSEWOOD CARE CENTER SWANSEA #0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			6,908	6,908		6,908	135,170	142,078			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,041,408	1,041,408			32
33	Real Estate Taxes			68,574	68,574		68,574		68,574			33
34	Rent-Facility & Grounds			1,039,269	1,039,269		1,039,269	(1,017,921)	21,348			34
35	Rent-Equipment & Vehicles			17,750	17,750		17,750		17,750			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,132,501	1,132,501		1,132,501	158,657	1,291,158			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,718	71,756	556,474		556,474		556,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		484,718	137,456	622,174		622,174		622,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,385,252	1,062,661	5,469,188	9,917,101		9,917,101	(1,047,072)	8,870,029			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,215)	2		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	(3,574)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,097)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(620)	2		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	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,214)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,173)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(593)	20		28
29	Other-Attach Schedule	(697,423)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (721,909)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(325,163)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (325,163)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,047,072)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

ROSEWOOD CARE CENTER SWANSEA

ID# 0032680

Report Period Beginning: 7/1/10

Ending: 6/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (89,156)	21	1
2	Eliminate Marketing Mileage	(5,556)	25	2
3	Eliminate Lobbying & PAC Dues	(2,711)	20	3
4	Eliminate Accrued Subsidence Costs	(600,000)	6	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(697,423)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA **#** 0032680 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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	0	0	(5,595)	0	0	0	0	0	0	0	0	(5,595)	1
2	Food Purchase	(10,932)	0	0	0	0	0	0	0	0	0	0	(10,932)	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	309	0	0	0	0	0	0	0	0	309	5
6	Maintenance	(600,000)	60,360	13,700	0	0	0	0	0	0	0	0	(525,940)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(610,932)	60,360	8,414	0	0	0	0	0	0	0	0	(542,158)	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	0	(320,883)	0	0	0	0	0	0	0	0	(320,883)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,214)	(75,392)	33,124	0	0	0	0	0	0	0	0	(47,482)	19
20	Fees, Subscriptions & Promotions	(7,477)	0	0	0	0	0	0	0	0	0	0	(7,477)	20
21	Clerical & General Office Expenses	(89,156)	1,542	(247,529)	0	0	0	0	0	0	0	0	(335,143)	21
22	Employee Benefits & Payroll Taxes	0	14,137	21,247	0	0	0	0	0	0	0	0	35,384	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,162	2,785	0	0	0	0	0	0	0	0	4,947	24
25	Other Admin. Staff Transportation	(5,556)	5,229	2,900	0	0	0	0	0	0	0	0	2,573	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,510	0	0	0	0	0	0	0	0	4,510	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(107,403)	(52,322)	(503,846)	0	0	0	0	0	0	0	0	(663,571)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(718,335)	8,038	(495,432)	0	0	0	0	0	0	0	0	(1,205,729)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	119,353	15,817	0	0	0	0	0	0	0	0	135,170	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,574)	1,044,847	135	0	0	0	0	0	0	0	0	1,041,408	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,039,269)	21,348	0	0	0	0	0	0	0	0	(1,017,921)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,574)	124,931	37,300	0	0	0	0	0	0	0	0	158,657	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(721,909)	132,969	(458,132)	0	0	0	0	0	0	0	0	(1,047,072)	45

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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
Rosewood Care Center Holding Co.	100	Section Not Applicable		HSM Management Svs, Inc.	St. Louis, MO	Management Co.
				Midwest Admin Svs, Inc.	St. Louis, MO	Administrative Co.
				Swansea Real Estate, Inc.	St. Louis, MO	Real Estate Lsg.
				Rosewood Home Health	St. Louis, MO	Home Health Co.
				Claims Administration		
				Services, LLC	St. Louis, MO	Legal Co.

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Swansea Real Estate, Inc.		$ 119,353	$ 119,353	1
2	V	32	Interest		Swansea Real Estate, Inc.		1,044,847	1,044,847	2
3	V	34	Rent	1,039,269	Swansea Real Estate, Inc.			(1,039,269)	3
4	V	6	Maintenance		Swansea Real Estate, Inc.		60,360	60,360	4
5	V								5
6	V								6
7	V								7
8	V	19	Professional Services	209,496	Claims Administration Services, LLC		134,104	(75,392)	8
9	V	21	Clerical & General Office Expenses		Claims Administration Services, LLC		1,542	1,542	9
10	V	22	Emp. Benefits & Payroll Taxes		Claims Administration Services, LLC		14,137	14,137	10
11	V	24	Travel & Seminar		Claims Administration Services, LLC		2,162	2,162	11
12	V	25	Other Admin Staff Transportation		Claims Administration Services, LLC		5,229	5,229	12
13	V								13
14	Total			$ 1,248,765			$ 1,381,734	$ * 132,969	14

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	See Schedule VIII	$ 9,600	HSM Management Services, Inc.		$ 4,005	$ (5,595)	15
16	V	5	See Schedule VIII		HSM Management Services, Inc.		309	309	16
17	V	6	See Schedule VIII		HSM Management Services, Inc.		13,700	13,700	17
18	V	17	See Schedule VIII	325,000	HSM Management Services, Inc.		4,117	(320,883)	18
19	V	19	See Schedule VIII		HSM Management Services, Inc.		33,124	33,124	19
20	V	21	See Schedule VIII	429,600	HSM Management Services, Inc.		182,071	(247,529)	20
21	V	22	See Schedule VIII		HSM Management Services, Inc.		21,247	21,247	21
22	V	24	See Schedule VIII		HSM Management Services, Inc.		2,785	2,785	22
23	V	25	See Schedule VIII		HSM Management Services, Inc.		2,900	2,900	23
24	V	26	See Schedule VIII		HSM Management Services, Inc.		4,510	4,510	24
25	V	30	See Schedule VIII		HSM Management Services, Inc.		15,817	15,817	25
26	V	32	See Schedule VIII		HSM Management Services, Inc.		135	135	26
27	V	34	See Schedule VIII		HSM Management Services, Inc.		21,348	21,348	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 764,200			$ 306,068	$ * (458,132)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Administrative	0.00	24,013	4.74	7.90	Salary	$ 2,058	17-8	1
2	Darrell Hoefling	Vice-President	Administrative	0.00	24,013	4.74	7.90	Salary	2,058	17-8	2
3											3
4											4
5	Larry Vander Maten	President	Administrative	0.00	0			Salary	115,000	17-1	5
6	Darrell Hoefling	Vice-President	Administrative	0.00	0			Salary	58,333	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 177,449		13

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

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 [X] NO [ ]

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

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost	111,461,570	19	$ 50,722	$ 50,722	8,799,907	$ 4,005	1
2	5	Utilities	Total Cost	111,461,570	19	3,918		8,799,907	309	2
3	6	Maintenance	Total Cost	111,461,570	19	173,522		8,799,907	13,700	3
4	17	Salaries - Officers	Total Cost	111,461,570	19	52,143	52,143	8,799,907	4,117	4
5	19	Professional Services	Total Cost	111,461,570	19	377,522		8,799,907	29,805	5
6	21	Salaries - Other	Total Cost	111,461,570	19	1,909,806	1,909,806	8,799,907	150,779	6
7	21	Clerical & Office Supplies	Total Cost	111,461,570	19	393,390		8,799,907	31,058	7
8	22	Payroll Taxes & Emp. Benefits	Total Cost	111,461,570	19	269,124		8,799,907	21,247	8
9	24	Travel & Seminar	Total Cost	111,461,570	19	29,846		8,799,907	2,356	9
10	25	Other Admin Staff Transp	Total Cost	111,461,570	19	36,732		8,799,907	2,900	10
11	26	Insurance	Total Cost	111,461,570	19	23,015		8,799,907	1,817	11
12	30	Depreciation	Total Cost	111,461,570	19	187,446		8,799,907	14,799	12
13	34	Building Rent	Total Cost	111,461,570	19	270,401		8,799,907	21,348	13
14	17	Direct - Admin	Direct Cost	1	1	70,000	70,000	0	0	14
15	19	Professional Services	Direct Cost	1	1	3,319		1	3,319	15
16	21	Office Supplies	Direct Cost	1	1	234		1	234	16
17	24	Travel & Seminar	Direct Cost	1	1	429		1	429	17
18	26	Insurance	Direct Cost	1	1	2,693		1	2,693	18
19	30	Direct - Depreciation	Direct Cost	1	1	1,018		1	1,018	19
20	30	Direct - Depreciation	Direct Cost	18	18	15,140		0	0	20
21	32	Interest	Direct Cost	1	1	135		1	135	21
22										22
23										23
24										24
25	TOTALS					$ 3,870,555	$ 2,082,671		$ 306,068	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Loan Refinancing	$85,143.00	10/26/99	$ 10,237,500	$ 8,669,248	11/2009	8.8900	$ 1,044,847	1
2	Related Party Allocation-HSM Mgt										135	2
3	Less: Interest Income Offest										(3,574)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$85,143.00		$ 10,237,500	$ 8,669,248			$ 1,041,408	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,237,500	$ 8,669,248			$ 1,041,408	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 **Report Period Beginning:** 7/1/10 **Ending:** 6/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 109,111	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 72,259	2
3. Under or (over) accrual (line 2 minus line 1).		$ (36,852)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 105,426	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 68,574	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	73,634	8
	2007	76,246	9
	2008	74,507	10
	2009	72,259	11
	2010	62,881	12

2009 Payments = $72,259

Accrual = Balance of 2010 tax bill ($62,881) + 1/2 of estimated 2011 tax bill ($42,545)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSEWOOD CARE CENTER SWANSEA COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-09.0-402-023	Wandering Woods	$ 62,881.20	$ 62,881.20
2.		LOT/SEC-3 BK 52855-554 & 3023-25	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,881.20	$ 62,881.20

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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 [X] 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	Nursing Home	6.8097 Acres	1987	$ 126,031	1
2					2
3	TOTALS	#VALUE!		$ 126,031	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1987	$ 2,175,969	$	20-25	$ 55,752	$ 55,752	$ 2,102,521	4
5				1988	253,539		25	10,141	10,141	229,881	5
6				1990	222,972		20-25	8,582	8,582	186,872	6
7				1991	6,679		25	267	267	5,274	7
8											8
	Improvement Type**										
9	Beam Water Hydrant			1988	1,677		10			1,677	9
10	Trees & Seeding			1988	745		10			745	10
11	Seeding			1988	4,290		10			4,290	11
12	End Parking Lot Expansion			1988	621		25	25	25	572	12
13	Landscaping			1989	1,904		25	76	76	1,711	13
14	Road			1990	431,970		25	17,279	17,279	362,857	14
15	Parking Lot Expansion			1989	27,592		15			27,592	15
16	Lawn Sprinkler System			1992	10,926		25	437	437	8,194	16
17	Backflow for Sprinkler			1993	2,909		10	116	116	2,110	17
18	Landscaping/Fencing			1987	25,279		25	1,011	1,011	24,012	18
19	Sinks			1987	4,156		10			4,156	19
20	Walk-In Cooler			1987	5,515		10			5,515	20
21	Exhaust Hood			1987	6,498		10			6,498	21
22	Hand Sinks			1987	181		10			181	22
23	Paging Systems			1987	632		10			632	23
24	Carpet			1987	39,910		10			39,910	24
25	Hospital Track/Curtain			1987	8,075		10			8,075	25
26	Signs			1987	2,916		10			2,916	26
27	Telephone Equipment			1987	3,180		10			3,180	27
28	Outside Sign			1987	4,504		10			4,504	28
29	Water Heater			1988	3,650		10			3,650	29
30	Walk-In Freezer			1988	3,936		15			3,936	30
31	Nurse Call System			1989	670		15			670	31
32	Sign			1989	2,000		10			2,000	32
33	Exhaust Fan			1989	530		10			530	33
34	Water Treatment System			1989	5,905		10			5,905	34
35	Door Guard			1989	5,509		10			5,509	35
36	Corner Guard			1990	1,446		10			1,446	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	1990	$ 2,215	$	10	$	$	$ 2,215	37
38	Hot Water Storage Tank	1996	2,607		10			2,607	38
39	Heat Pumps	2003	3,746		10	375	375	2,966	39
40	Roof Work	2004	21,620		40	541	541	3,784	40
41	Storage Building	2004	13,980		25	559	559	3,728	41
42	Parking Lot Seal & Stripe	2004	3,993		2			3,993	42
43	Telephone Power Pole	2005	10,875		10	1,087	1,087	6,435	43
44	Fire Alarm System	2005	9,668		10	967	967	5,559	44
45	Satellite System	2006	9,002		10	900	900	4,726	45
46	Heat Pumps	2007	37,285		10	3,729	3,729	15,670	46
47	Evaporative Cooling Tower	2007	48,252		10	4,825	4,825	20,105	47
48	Water Heater	2007	3,545		10	354	354	1,359	48
49	Compressor Blower Motor	2007	2,938		10	294	294	1,151	49
50	Water Heater	2007	3,594		10	360	360	1,349	50
51	Electrical Wiring	2009	3,153		10	315	315	762	51
52	Painting Exterior of Building	2010	8,792		40	220	220	238	52
53	Heat Pumps	2009	6,327		10	633	633	1,055	53
54	Exterior Doors	2009	9,014		10	901	901	1,502	54
55	Wall Cabinets	2009	1,009		10	101	101	168	55
56	Sprinkler Pipe	2010	14,909		10	1,491	1,491	1,864	56
57	Water Heater	2010	4,040		10	404	404	471	57
58	Cooling Tower Fan	2011	4,554		10	38	38	38	58
59	Seal & Stripe Parking Lot	2010	4,839		25	129	129	129	59
60									60
61									61
62	Leasehold Improvements - Facility:								62
63	Carpet/Tile/Painting - Nurse Call Station	1993	20,471		7			20,471	63
64	Painting/Wallpaper	1994	15,422		7			15,422	64
65	Painting/Wallpaper/Tile	1995	25,375		7			25,375	65
66	Shelving	1995	2,186		7			2,186	66
67	New Upholstery	1995	513		7			513	67
68	Design Work	1995	128		7			128	68
69	Carpeting	1996	5,580		7			5,580	69
70	TOTAL (lines 4 thru 69)		$ 3,565,917	$		$ 111,909	$ 111,909	$ 3,209,070	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,565,917	$		$ 111,909	$ 111,909	$ 3,209,070	1
2	Painting/Tiling	1996	6,383		7			6,383	2
3	Painting	1997	3,025		7			3,025	3
4	Tile & Base 2 Rooms	1997	1,400		7			1,400	4
5	2 Oak Doors	1997	803		7			803	5
6	Carpet & Installation	1998	7,951		7			7,951	6
7	Shower Renovations	1998	16,869		7			16,869	7
8	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	8
9	Shower Room	1998	18,424		7			18,424	9
10	Wallpaper	1999	273		7			273	10
11	Painting	1998	970		7			970	11
12	Wallpaper	1998	5,103		7			5,103	12
13	Carpet/Installation	1998	5,106		7			5,106	13
14	Phone System	1998	8,703		7			8,703	14
15	Wallpaper	1998	4,450		7			4,450	15
16	Drapery	2000	31,964		7			31,964	16
17	Computer Cabling	2000	2,392		7			2,392	17
18	Painting	2001	18,240		7			18,240	18
19	Cabling	2001	606		7			606	19
20	Carpet	2002	1,150		7			1,150	20
21	Wallcovering	2004	3,554	169	7	169		3,554	21
22	Drywall	2004	6,594	942	7	942		6,359	22
23	Shelving	2004	2,271	325	7	325		2,190	23
24	Tile & Base 2 Rooms	2004	5,918	845	7	845		5,566	24
25	Floor Tile & Base	2005	4,203	601	7	601		3,402	25
26	Parking Lot Striping & Sealing	2005	3,993	571	7	571		3,232	26
27	Repair Water Damaged Rooms	2005	6,141	877	7	877		4,898	27
28	Drapes	2006	4,666	667	7	667		3,055	28
29	Carpet	2009	13,379	1,911	7	1,911		4,300	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,752,281	$ 6,908		$ 118,817	$ 111,909	$ 3,381,271	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	$ 117,716	$	$ 15,512	$ 15,512	5-10 Yrs.	$ 93,926	71
72	Current Year Purchases	8,718		266	266	5-10 Yrs.	266	72
73	Fully Depreciated Assets	507,321					507,321	73
74								74
75	TOTALS	$ 633,755	$	$ 15,778	$ 15,778		$ 601,513	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	HSM Management	Various	Various	$ 38,065	$	$ 7,483	$ 7,483	4	$ 22,977	76
77										77
78										78
79										79
80	TOTALS			$ 38,065	$	$ 7,483	$ 7,483		$ 22,977	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,550,132	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,908	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,078	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 135,170	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,005,761	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	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule 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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	$	18,105	$ 307,214	$	18,105	$ 307,214	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		6,127	118,034		6,127	118,034	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		25,359	424,463	8,635	25,359	433,098	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				484,718		484,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Labs, X-Rays, Enterals	39, 3				71,756			71,756	12
13	Other (specify):									13
14	TOTAL			$	49,591	$ 921,467	$ 493,353	49,591	$ 1,414,820	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11 (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	$ 2,098	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	657,281		3
4	Supply Inventory (priced at Cost)	4,554		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,586		6
7	Other Prepaid Expenses	88,577		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 775,096	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	256,039		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(241,877)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	2,467		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,629	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 791,725	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 871,308	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,467		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,644		31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,426		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,700		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	144,214		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,365,759	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,365,759	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (574,034)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 791,725	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (113,620)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (113,620)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(460,414)	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)**	$ (460,414)	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)**	$ (574,034)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,751,116	1
2	Discounts and Allowances for all Levels	(2,600,244)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,150,872	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,289,218	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,289,218	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,200	13
14	Non-Patient Meals	9,215	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)**	$ 11,415	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,574	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,574	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vendor Discounts	1,097	28
28a	Miscellaneous	511	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,608	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,456,687	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,913,023	31
32	Health Care	3,583,646	32
33	General Administration	2,665,757	33
	B. Capital Expense		
34	Ownership	1,132,501	34
	C. Ancillary Expense		
35	Special Cost Centers	556,474	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,917,101	40
41	**Income before Income Taxes (line 30 minus line 40)****	(460,414)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (460,414)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,978	2,122	$ 75,245	$ 35.46	1
2	Assistant Director of Nursing	1,859	1,995	63,675	31.92	2
3	Registered Nurses	20,580	22,080	604,481	27.38	3
4	Licensed Practical Nurses	28,717	30,810	618,270	20.07	4
5	CNAs & Orderlies	72,072	77,326	794,122	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,994	6,431	114,314	17.78	8
9	Activity Director					9
10	Activity Assistants	5,560	5,965	57,908	9.71	10
11	Social Service Workers	4,112	4,412	62,078	14.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,925	22,451	214,578	9.56	15
16	Dishwashers					16
17	Maintenance Workers	1,905	2,044	29,733	14.55	17
18	Housekeepers	16,184	17,364	165,612	9.54	18
19	Laundry	5,449	5,846	50,465	8.63	19
20	Administrator	1,688	1,811	71,606	39.54	20
21	Assistant Administrator					21
22	Other Administrative			173,333		22
23	Office Manager					23
24	Clerical	10,950	11,748	181,525	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,872	6,300	108,307	17.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,845	218,705	$ 3,385,252 *	$ 15.48	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 7,401	1,3	35
36	Medical Director	Contract	5,500	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,470	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,400	11,3	44
45	Social Service Consultant	Contract	2,400	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,171		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	172	$ 6,942	10-3	50
51	Licensed Practical Nurses	348	11,321	10-3	51
52	Certified Nurse Assistants/Aides	40	635	10-3	52
53	TOTAL (lines 50 - 52)	560	$ 18,898		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Kabureck	Administrative	0	$ 71,606
Larry Vander Maten	Administrative		115,000
Darrell Hoefling	Administrative		58,333
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 244,939

B. Administrative - Other

Description	Amount
Management Fees - HSM Management Services	$ 325,000
Bravo Nursing Home Services Fees	264,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 589,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached		$ 322,271
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 322,271

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,198
Unemployment Compensation Insurance	60,681
FICA Taxes	245,536
Employee Health Insurance	68,165
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement	1,139
Employee Uniforms	1,169
Employee Relations	1,908
Employee Drug Test	120
Related Party Allocation	35,384
TOTAL (agree to Schedule V, line 22, col.8)	$ 512,300

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	5,825
Health Care Worker Background Check	7,148
(Indicate # of checks performed)	
Patient Background Checks	
IHCA Dues	4,158
Misc. Dues/Subscriptions	631
Promotional Advertising	1,766
Less: Public Relations Expense	( )
Non-allowable advertising	(1,173)
Yellow page advertising	(593)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,757

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party Allocation	4,947
Seminar Expense	783
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,730

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER SWANSEA # 0032680 Report Period Beginning: 7/1/10 Ending: 6/30/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,158**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,072** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
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? **N/A**

(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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,215**

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF SWANSEA
IDPH ID #0032680
Attachment to Schedule XIX, Section C
6/30/2011

Vendor	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	5,250
Becker Paulson Hoerner & Thompson	Allowable Legal Fees	3,167
Becker Paulson Hoerner & Thompson	Out of Period Fees	558
Daniel Maher	Collections	4,656
Daniel Maher	Allowable Legal Fees	3,015
Old Republic Surety Group	Surety Bond	100
SJM & Co, Inc.	Consulting	293
Summers Compton Wells, PC	Allowable Legal Fees	1,211
Atkinson-Baker, Court Reporters	Court Reporters	731
Belleville News Democrat	Public Notices	84
Clark and Associates Inc.	Deopsition Fee	378
Clerk of the Circuit Court	Court Fees	863
DosterUllom, LLC	Allowable Legal Fees	72,523
ElderCare Decisions, Inc.	Specialist Analysis	1,319
GorePerry Reporting and Video	Court Reporters	100
HealthPort	Hospital Medical Records	65
Karen D. Chatham, CSR	Transcription Fee	281
Keefe Reporting Company	Court Report Copies	167
Kevin Baumer, MD	Physician Deposition Fee	1,200
Matthew Hageman, MD	Physician Deposition Fee	1,500
Open Delta Consulting, LLC	Trial Consultation	12,814
William M. Ricci, MD	Physician Deposition Fee	1,500
Claims Administration Services, Inc.	Related Party Legal Fees	209,496
Hovan Management	Escrow Fee	1,000
		322,271