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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0032680

Facility Name: Rosewood Care Ctr of Swansea

Address: 100 Rosewood Vlg Dr (Number) Swansea (City) 62226 (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 7/1/14 to 6/30/15 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 Accountants' Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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			8,817	8,817	8
9	SNF/PED					9
10	ICF	6,907	16,251	248	23,406	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,907	16,251	9,065	32,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.57%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 10/08/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/08/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 5,725

Medicare Intermediary Novitas Solution, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	234,571	15,155	9,078	258,804		258,804		258,804			1
2	Food Purchase		234,105		234,105		234,105	(2,290)	231,815			2
3	Housekeeping	176,441	36,326		212,767		212,767		212,767			3
4	Laundry	54,431	18,688		73,119		73,119		73,119			4
5	Heat and Other Utilities			135,919	135,919		135,919		135,919			5
6	Maintenance	53,093	1,831	164,048	218,972		218,972	49,231	268,203			6
7	Other (specify):* Waste Disposal			19,875	19,875		19,875		19,875			7
8	TOTAL General Services	518,536	306,105	328,920	1,153,561		1,153,561	46,941	1,200,502			8
	B. Health Care and Programs											
9	Medical Director			6,844	6,844		6,844		6,844			9
10	Nursing and Medical Records	2,233,712	210,114	165,756	2,609,582		2,609,582		2,609,582			10
10a	Therapy	157,698	2,545		160,243		160,243		160,243			10a
11	Activities	59,687	5,321	2,688	67,696		67,696		67,696			11
12	Social Services	79,396		1,800	81,196		81,196		81,196			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,530,493	217,980	177,088	2,925,561		2,925,561		2,925,561			16
	C. General Administration											
17	Administrative	97,246		420,000	517,246		517,246	(316,705)	200,541			17
18	Directors Fees											18
19	Professional Services			54,066	54,066		54,066	251,730	305,796			19
20	Dues, Fees, Subscriptions & Promotions			24,675	24,675	(1,063)	23,612	(6,875)	16,737			20
21	Clerical & General Office Expenses	192,689	33,324	66,957	292,970		292,970		292,970			21
22	Employee Benefits & Payroll Taxes			512,703	512,703		512,703	4,895	517,598			22
23	Inservice Training & Education											23
24	Travel and Seminar			61	61	1,063	1,124	192	1,316			24
25	Other Admin. Staff Transportation			3,720	3,720		3,720	763	4,483			25
26	Insurance-Prop.Liab.Malpractice			98,499	98,499		98,499	1,384	99,883			26
27	Other (specify):*											27
28	TOTAL General Administration	289,935	33,324	1,180,681	1,503,940		1,503,940	(64,616)	1,439,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,338,964	557,409	1,686,689	5,583,062		5,583,062	(17,675)	5,565,387			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 Ctr of Swansea #0032680 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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			25,037	25,037		25,037	48,997	74,034			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77	77		77	230	307			32
33	Real Estate Taxes			64,782	64,782		64,782		64,782			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			35,160	35,160		35,160		35,160			35
36	Other (specify):* **Income Taxes**			97,260	97,260		97,260	(97,260)				36
37	**TOTAL Ownership**			630,316	630,316		630,316	(456,033)	174,283			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		294,351	885,991	1,180,342		1,180,342		1,180,342			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,563	228,563		228,563	(4,374)	224,189			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		294,351	1,114,554	1,408,905		1,408,905	(4,374)	1,404,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,338,964	851,760	3,431,559	7,622,283		7,622,283	(478,082)	7,144,201			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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	(2,290)	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	(1,134)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,374)	42		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,253)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,454)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(97,260)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(351)	20		28
29	Other-Attach Schedule	(1,105)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,221)		$	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)	(342,861)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (342,861)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (478,082)		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 **Page 5A**

Rosewood Care Ctr of Swansea

ID# **0032680**

Report Period Beginning: **7/1/14**

Ending: **6/30/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate lobbying & PAC dues	$ (3,095)	20	1
2	Add back 1/2 of 2 yr IDPH license paid in 2014	1,990	20	2
3				3
4				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**	(1,105)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Swansea **#** 0032680 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,290)	0	0	0	0	0	0	0	0	0	0	(2,290)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	49,231	0	0	0	0	0	0	0	0	0	49,231	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,290)	49,231	0	0	0	0	0	0	0	0	0	46,941	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	(316,705)	0	0	0	0	0	0	0	0	0	(316,705)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,253)	274,983	0	0	0	0	0	0	0	0	0	251,730	19
20	Fees, Subscriptions & Promotions	(6,910)	35	0	0	0	0	0	0	0	0	0	(6,875)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	4,895	0	0	0	0	0	0	0	0	0	4,895	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	192	0	0	0	0	0	0	0	0	0	192	24
25	Other Admin. Staff Transportation	0	763	0	0	0	0	0	0	0	0	0	763	25
26	Insurance-Prop.Liab.Malpractice	0	1,384	0	0	0	0	0	0	0	0	0	1,384	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(30,163)	(34,453)	0	0	0	0	0	0	0	0	0	(64,616)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,453)	14,778	0	0	0	0	0	0	0	0	0	(17,675)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	48,997	0	0	0	0	0	0	0	0	0	48,997	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,134)	1,364	0	0	0	0	0	0	0	0	0	230	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(408,000)	0	0	0	0	0	0	0	0	0	(408,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(97,260)	0	0	0	0	0	0	0	0	0	0	(97,260)	36
37	**TOTAL Ownership**	(98,394)	(357,639)	0	0	0	0	0	0	0	0	0	(456,033)	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	(4,374)	0	0	0	0	0	0	0	0	0	0	(4,374)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(4,374)	0	0	0	0	0	0	0	0	0	0	(4,374)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,221)	(342,861)	0	0	0	0	0	0	0	0	0	(478,082)	45

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 N/A		SILDA LLC	St. Louis, MO	Real Estate Lsg
				HSM Management Svc	St. Louis, MO	Management Co.
				Claims Admin Svcs, L	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	34	Rent	$ 408,000	SILDA LLC		$	$ (408,000)	1
2	V	6	Maintenance		SILDA LLC		49,231	49,231	2
3	V	30	Depreciation		SILDA LLC		48,997	48,997	3
4	V								4
5	V	17	Administrative	420,000	HSM Management		103,295	(316,705)	5
6	V	19	Professional Services		HSM Management		274,983	274,983	6
7	V	22	Employee Benefits		HSM Management		4,895	4,895	7
8	V	20	Dues, Fees, Subs & Promos		HSM Management		35	35	8
9	V	24	Travel & Seminar		HSM Management		192	192	9
10	V	25	Transportation		HSM Management		763	763	10
11	V	26	Insurance		HSM Management		1,384	1,384	11
12	V	32	Interest		HSM Management		1,364	1,364	12
13	V								13
14	Total			$ 828,000			$ 485,139	$ * (342,861)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Owner	Administrative	50.00	0	5	13.00	Admin	$ 7,500	17,8	1
2	Darrell Hoefling	Owner	Administrative	50.00	0	5	13.00	Admin	7,500	17,8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,000		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										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					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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				Schedule N/A			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

*** 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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 97,172	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.)		$ 95,447	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,725)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,507	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.		$ 64,782	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	62,881	8
	2011	65,275	9
	2012	63,511	10
	2013	63,080	11
	2014	64,735	12

Line 2: 2013 taxes of $63,080 plus 1st installment of 2014 taxes of $32,367 = $95,447 paid

Line 4: 1/2 year of the 2014 taxes due, plus 1/2 year estimated for 1/1/15-6/30/15.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Swansea COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

TELEPHONE 618-465-7717 FAX #: 618-465-7710

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-09.0-402-023	Wandering Woods	$ 64,734.56	$ 64,734.56
2.		Lot/SEC-3 BK2855-554 & 3023-25	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,734.56	$ 64,734.56

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 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.

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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				1987	$ 2,175,969	$	20-25	$	$	$ 2,175,969	4
5				1988	253,539		25			253,539	5
6				1990	222,972		20-25	8,115	8,115	220,265	6
7				1991	6,679		25	267	267	6,343	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			621	12
13	Landscaping			1989	1,904		25			1,904	13
14	Road			1990	431,970		25	17,276	17,276	431,970	14
15	Parking Lot Expansion			1989	27,592		15			27,592	15
16	Lawn Sprinkler System			1992	10,926		25	437	437	9,942	16
17	Backflow for Sprinkler			1993	2,909		10	116	116	2,576	17
18	Landscaping/Fencing			1987	25,279		25			25,279	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.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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			3,746	39
40	Roof Work	2004	21,620		40	541	541	5,945	40
41	Storage Building	2004	13,980		25	559	559	5,965	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	10,784	43
44	Fire Alarm System	2005	9,668		10	967	967	9,426	44
45	Satellite System	2006	9,002		10	900	900	8,327	45
46	Heat Pumps	2007	37,285		10	3,729	3,729	30,584	46
47	Evaporative Cooling Tower	2007	48,252		10	4,825	4,825	39,406	47
48	Water Heater	2007	3,545		10	355	355	2,777	48
49	Compressor Blower Motor	2007	2,938		10	294	294	2,326	49
50	Water Heater	2007	3,594		10	359	359	2,786	50
51	Electrical Wiring	2009	3,153		10	315	315	2,023	51
52	Painting Exterior of Building	2010	8,792		40	220	220	1,117	52
53	Heat Pumps	2009	6,327		10	633	633	3,585	53
54	Exterior Doors	2009	9,014		10	901	901	5,108	54
55	Wall Cabinets	2009	1,009		10	101	101	572	55
56	Sprinkler Pipe	2010	14,909		10	1,491	1,491	7,827	56
57	Water Heater	2010	4,040		10	404	404	2,087	57
58	Cooling Tower Fan	2011	4,554		10	455	455	1,859	58
59	Seal & Stripe Parking Lot	2010	4,839		25	194	194	903	59
60	Heat Pumps	2012	5,218		10	522	522	1,739	60
61	Interior/Exterior Doors	2013	6,951		10	695	695	1,448	61
62	Impairment loss		(418,840)						62
63	Leasehold Improvements - Facility:								63
64	Carpet/Tile/Painting - Nurse Call Station	1993	20,471		7			20,471	64
65	Painting/Wallpaper	1994	15,422		7			15,422	65
66	Painting/Wallpaper/Tile	1995	25,375		7			25,375	66
67	Shelving	1995	2,186		7			2,186	67
68	New Upholstery	1995	513		7			513	68
69	Design Work	1995	128		7			128	69
70	TOTAL (lines 4 thru 69)		$ 3,153,666	$		$ 45,758	$ 45,758	$ 3,485,175	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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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		$ 3,153,666	$		$ 45,758	$ 45,758	$ 3,485,175	1
2	Carpeting	1996	5,580		7			5,580	2
3	Painting/Tiling	1996	6,383		7			6,383	3
4	Painting	1997	3,025		7			3,025	4
5	Tile & Base 2 Rooms	1997	1,400		7			1,400	5
6	2 Oak Doors	1997	803		7			803	6
7	Carpet & Installation	1998	7,951		7			7,951	7
8	Shower Renovations	1998	16,869		7			16,869	8
9	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	9
10	Shower Room	1998	18,424		7			18,424	10
11	Wallpaper	1999	273		7			273	11
12	Painting	1998	970		7			970	12
13	Wallpaper	1998	5,103		7			5,103	13
14	Carpet/Installation	1998	5,106		7			5,106	14
15	Phone System	1998	8,703		7			8,703	15
16	Wallpaper	1998	4,450		7			4,450	16
17	Drapery	2000	31,964		7			31,964	17
18	Computer Cabling	2000	2,392		7			2,392	18
19	Painting	2001	18,240		7			18,240	19
20	Cabling	2001	606		7			606	20
21	Carpet	2002	1,150		7			1,150	21
22	Wallcovering	2004	3,554		7			3,554	22
23	Drywall	2004	6,594		7			6,594	23
24	Shelving	2004	2,271		7			2,271	24
25	Tile & Base 2 Rooms	2004	5,918		7			5,918	25
26	Floor Tile & Base	2005	4,203		7			4,203	26
27	Parking Lot Striping & Sealing	2005	3,993		7			3,993	27
28	Repair Water Damaged Rooms	2005	6,141		7			6,141	28
29	Drapes	2006	4,666		7			4,666	29
30	Carpet	2009	13,379	1,911	7	1,911		11,786	30
31	Water Heater	2011	4,780	683	7	683		2,561	31
32	Telephone System	2011	27,729	3,961	7	3,961		14,880	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,378,119	$ 6,555		$ 52,313	$ 45,758	$ 3,692,967	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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12B, Carried Forward		$ 3,378,119	$ 6,555		$ 52,313	$ 45,758	$ 3,692,967	1
2	Cooling Tower Fan Motor Repair	2011	4,554	651	7	651		2,603	2
3	3 door freezer	2011	5,056	722	7	722		2,889	3
4	Flooring - 400, 500 corridors, 100/200 & 400/500 nurses station	2013	4,916	702	7	702		1,521	4
5	main & assisted dining rooms, mechanical wing, therapy								5
6	wing, 500 corridor bathing suite, rooms 501, 503, 402, 404, 516 & 517								6
7	Lobby Floor	2014	2,200	209	7	209		209	7
8	Lobby Walls	2014	3,400	243	7	243		243	8
9	Parking Lot paved	2015	4,980		7				9
10	Purchase & install 8 doors	2013	3,476		40	87	87	154	10
11	Water Heater	2015	6,699		10	167	167	167	11
12	AC's/Heat Pumps	2015	5,310		10	221	221	221	12
13	Landscaping	2013	3,310		25	132	132	220	13
14	Landscaping	2015	5,375		25				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	TOTAL (lines 1 thru 33)		$ 3,427,395	$ 9,082		$ 55,447	$ 46,365	$ 3,701,194	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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 78,728	$ 10,852	$ 11,514	$ 662	10-15	$ 24,328	71
72	Current Year Purchases	18,678	1,600	1,676	76	10	1,676	72
73	Fully Depreciated Assets	575,019		1,894	1,894	10	575,019	73
74								74
75	TOTALS	$ 672,425	$ 12,452	$ 15,084	$ 2,632		$ 601,023	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2014 Bus	2014	$ 36,777	$ 3,503	$ 3,503	$	7	$ 3,503	76
77										77
78										78
79										79
80	TOTALS			$ 36,777	$ 3,503	$ 3,503	$		$ 3,503	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)	$ 4,262,628	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,037	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 74,034	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 48,997	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,305,720	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 N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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	Schedule N/A		$	$	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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				2,545		2,545	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				294,351		294,351	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): PT, OT, ST, Labs, Xra	39,3				885,991			885,991	13
14	TOTAL			$		$ 885,991	$ 296,896		$ 1,182,887	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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (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	$ 432,351	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,686)	1,116,078		3
4	Supply Inventory (priced at)	5,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	86,894		6
7	Other Prepaid Expenses	13,763		7
8	Accounts Receivable (owners or related parties)	98,928		8
9	Other(specify): Prepaid Taxes	3,789		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,756,803	$	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	313,654		15
16	Equipment, at Historical Cost	124,160		16
17	Accumulated Depreciation (book methods)	(303,283)		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)**	$ 136,998	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,893,801	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 296,413	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,324		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,660		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,507		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	63,790		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 617,694	$	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	Chapter 11 Settlement Payable	2,872		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,872	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 620,566	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,273,235	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,893,801	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,358,711	1
2	Restatements (describe):		2
3	**Prior Year Rent Adjustment**	(68,000)	3
4	**Prior Year Vac Accrual adjustment**	(20,224)	4
5	**Other Prior Year Adjustments**	120,682	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,391,169	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,066	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	(200,000)	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)**	$ (117,934)	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)**	$ 1,273,235	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,890,969	1
2	Discounts and Allowances for all Levels	(1,899,098)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,991,871	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,705,716	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,705,716	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	3,025	13
14	Non-Patient Meals	2,290	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)**	$ 5,315	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,134	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,134	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	313	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 313	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,704,349	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,153,561	31
32	Health Care	2,925,561	32
33	General Administration	1,503,940	33
	B. Capital Expense		
34	Ownership	630,316	34
	C. Ancillary Expense		
35	Special Cost Centers	1,180,342	35
36	Provider Participation Fee	228,563	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,622,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	82,066	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 82,066	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,010,879	44
45	Private Pay - Net Inpatient Revenue	2,854,406	45
46	Medicare - Net Inpatient Revenue	1,580,141	46
47	Other-(specify) Managed Care/Ins	546,445	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,991,871	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	1,279	1,380	$ 54,384	$ 39.41	1
2	Assistant Director of Nursing	1,884	2,033	72,788	35.80	2
3	Registered Nurses	16,526	17,828	507,006	28.44	3
4	Licensed Practical Nurses	26,996	29,123	613,427	21.06	4
5	CNAs & Orderlies	81,235	87,636	930,632	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,614	8,214	157,698	19.20	8
9	Activity Director					9
10	Activity Assistants	5,251	5,664	59,687	10.54	10
11	Social Service Workers	4,519	4,876	79,396	16.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,132	22,797	234,571	10.29	15
16	Dishwashers					16
17	Maintenance Workers	2,527	2,726	53,093	19.48	17
18	Housekeepers	15,722	16,960	176,441	10.40	18
19	Laundry	5,360	5,782	54,431	9.41	19
20	Administrator	1,960	2,114	97,246	46.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,751	11,598	192,689	16.61	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	3,438	3,709	55,475	14.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,194	222,440	$ 3,338,964 *	$ 15.01	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	$ 9,078	1,3	35
36	Medical Director	Contract	6,844	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,395	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	2,688	11,3	44
45	Social Service Consultant	Contract	1,800	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,805		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	870	$ 34,796	10,3	50
51	Licensed Practical Nurses	3,419	102,564	10,3	51
52	Certified Nurse Assistants/Aides	1,250	25,001	10,3	52
53	TOTAL (lines 50 - 52)	5,539	$ 162,361		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Kabureck	Administrator	0	$ 14,152
Brian Koontz	Administrator	0	81,306
Gail Kimmle	Administrator	0	1,788
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,246

B. Administrative - Other

Description	Amount
Management Fees-HSM Management Services	$ 420,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 420,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser	Accounting/Consulting	$ 5,615
Daniel Maher	Non-allowable Legal Fees	23,253
SJM & Co.	Accounting/Consulting	4,200
Summers, Compton, Wells	Allowable Legal Fees	790
First Advantage Tax Consulting	Accounting/Consulting	607
Saric Consulting	Medicaid Consulting	2,313
Madison County Record	Legal Fees	26
Steven Hamburg PC	Legal Fees	121
Clifton Larson Allen	Accounting/Consulting	11,730
Marsh	Insurance Fee	175
Retirement Plan Associates	401k consulting	650
Receiver Fees	Receiver Fees	4,586
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 54,066

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,723
Unemployment Compensation Insurance	48,883
FICA Taxes	260,903
Employee Health Insurance	47,839
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement	77
Employee Drug Tests	336
Uniforms	905
Employee Relations	6,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 517,598

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

Description	Line #	Amount
Schedule N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,499
Health Care Worker Background Check	
(Indicate # of checks performed 126)	2,532
Patient Background Checks	
IHCA Allowable Dues	4,105
Other Dues & Subscriptions	1,390
Licenses & Fees	1,221
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,737

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	253
Seminar Expense	1,063
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,316

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Ctr of Swansea # 0032680 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 $4,105**

(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. $ **61,905** 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 **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** 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. $ **224,189**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **2,290**

(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? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? 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) 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.