

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0032680 Facility Name: Rosewood Care Center Swansea Address: 100 Rosewood Village Drive Swansea 62226 County: St. Clair Telephone Number: (618)236-1391 Fax # (618)236-9622 HFS ID Number: Date of Initial License for Current Owners: 10/08/1987 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership X Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County 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 07/01/2011 to 06/30/2012 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) (Type or Print Name) (Title) Paid Preparer (Signed) See Accountant's Compilation Report (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
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>9,515</u>	<u>9,515</u>	8
9	SNF/PED					9
10	ICF	<u>3,354</u>	<u>22,598</u>		<u>25,952</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,354</u>	<u>22,598</u>	<u>9,515</u>	<u>35,467</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.75%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/08/1987

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

YES ☒Date 10/08/1987NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 48 and days of care provided 9,515Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	228,015	20,824	17,386	266,225		266,225	(5,179)	261,046		1
2	Food Purchase		187,653		187,653		187,653	(7,919)	179,734		2
3	Housekeeping	169,385	32,625		202,010		202,010		202,010		3
4	Laundry	52,459	29,136		81,595		81,595		81,595		4
5	Heat and Other Utilities			152,733	152,733		152,733	326	153,059		5
6	Maintenance	32,851	5,366	306,294	344,511		344,511	11,535	356,046		6
7	Other (specify):* Waste Disposal			14,542	14,542		14,542		14,542		7
8	TOTAL General Services	482,710	275,604	490,955	1,249,269		1,249,269	(1,237)	1,248,032		8
	B. Health Care and Programs										
9	Medical Director			5,319	5,319		5,319		5,319		9
10	Nursing and Medical Records	2,249,598	186,926	74,333	2,510,857		2,510,857		2,510,857		10
10a	Therapy	134,028	2,106		136,134		136,134		136,134		10a
11	Activities	52,607	3,993	2,400	59,000		59,000		59,000		11
12	Social Services	64,864		2,400	67,264		67,264		67,264		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,501,097	193,025	84,452	2,778,574		2,778,574		2,778,574		16
	C. General Administration										
17	Administrative	214,875		516,000	730,875		730,875	(85,934)	644,941		17
18	Directors Fees										18
19	Professional Services			785,485	785,485		785,485	(155,712)	629,773		19
20	Dues, Fees, Subscriptions & Promotions			21,472	21,472	4,430	25,902	(11,718)	14,184		20
21	Clerical & General Office Expenses	186,307	97,796	440,324	724,427		724,427	(351,916)	372,511		21
22	Employee Benefits & Payroll Taxes			495,969	495,969		495,969	27,461	523,430		22
23	Inservice Training & Education										23
24	Travel and Seminar			36,486	36,486	(4,430)	32,056	(24,008)	8,048		24
25	Other Admin. Staff Transportation			8,346	8,346		8,346	(1,694)	6,652		25
26	Insurance-Prop.Liab.Malpractice			186,493	186,493		186,493	1,876	188,369		26
27	Other (specify):*										27
28	TOTAL General Administration	401,182	97,796	2,490,575	2,989,553		2,989,553	(601,645)	2,387,908		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,384,989	566,425	3,065,982	7,017,396		7,017,396	(602,882)	6,414,514		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,537	10,537		10,537	126,714	137,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			472	472		472	1,131,544	1,132,016			32
33	Real Estate Taxes			66,496	66,496		66,496		66,496			33
34	Rent-Facility & Grounds			1,156,600	1,156,600		1,156,600	(1,134,705)	21,895			34
35	Rent-Equipment & Vehicles			13,926	13,926		13,926		13,926			35
36	Other (specify):*											36
37	TOTAL Ownership			1,248,031	1,248,031		1,248,031	123,553	1,371,584			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		345,744	908,585	1,254,329		1,254,329		1,254,329			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,800	225,800		225,800		225,800			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		345,744	1,134,385	1,480,129		1,480,129		1,480,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,384,989	912,169	5,448,398	9,745,556		9,745,556	(479,329)	9,266,227			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: 07/01/2011 Ending: 06/30/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,435)	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	(3,894)	32		10
11	Discounts, Allowances, Rebates & Refunds	(892)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(592)	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	(29,706)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,243)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(948)	20		28
29	Other-Attach Schedule	(145,091)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (193,801)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(285,528)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (285,528)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (479,329)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Swansea

ID# 0032680

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Marketing Salary	\$ (94,032)	21	1
2	Eliminate Marketing Mileage	(7,233)	25	2
3	Eliminate Lobbying & PAC Dues	(2,860)	20	3
4	Eliminate Out of Period IDPH License Fees	(1,990)	20	4
5	Eliminate Officer Travel Expenses	(31,783)	24	5
6	Eliminate Marketing Payroll Taxes	(7,193)	22	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	(145,091)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	(5,179)	0	0	0	0	0	0	0	0	(5,179)	1
2	Food Purchase	(7,919)	0	0	0	0	0	0	0	0	0	0	(7,919)	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	326	0	0	0	0	0	0	0	0	326	5
6	Maintenance	0	0	11,535	0	0	0	0	0	0	0	0	11,535	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,919)	0	6,682	0	0	0	0	0	0	0	0	(1,237)	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	(85,934)	0	0	0	0	0	0	0	0	(85,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,706)	(160,386)	34,380	0	0	0	0	0	0	0	0	(155,712)	19
20	Fees, Subscriptions & Promotions	(12,041)	323	0	0	0	0	0	0	0	0	0	(11,718)	20
21	Clerical & General Office Expenses	(94,032)	2,553	(260,437)	0	0	0	0	0	0	0	0	(351,916)	21
22	Employee Benefits & Payroll Taxes	(7,193)	15,730	18,924	0	0	0	0	0	0	0	0	27,461	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(31,783)	3,818	3,957	0	0	0	0	0	0	0	0	(24,008)	24
25	Other Admin. Staff Transportation	(7,233)	3,307	2,232	0	0	0	0	0	0	0	0	(1,694)	25
26	Insurance-Prop.Liab.Malpractice	0	100	1,776	0	0	0	0	0	0	0	0	1,876	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(181,988)	(134,555)	(285,102)	0	0	0	0	0	0	0	0	(601,645)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(189,907)	(134,555)	(278,420)	0	0	0	0	0	0	0	0	(602,882)	29

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 07/01/2011 Ending: 06/30/2012 Summary B

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	119,937	6,777	0	0	0	0	0	0	0	0	126,714	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,894)	1,135,438	0	0	0	0	0	0	0	0	0	1,131,544	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,156,600)	21,895	0	0	0	0	0	0	0	0	(1,134,705)	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	(3,894)	98,775	28,672	0	0	0	0	0	0	0	0	123,553	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)	(193,801)	(35,780)	(249,748)	0	0	0	0	0	0	0	0	(479,329)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rosewood Care Center Holding Co.	100	Section Not Applicable		HSM Management Sys	St. Louis, MO	Management Co.
				Midwest Admin Svs, I	St. Louis, MO	Administrative Co.
				Swansea Real Estate, I	St. Louis, MO	Real Estate Lsg.
				Rosewood Home Healt	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.

☒ 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	26	Insurance	\$	Swansea Real Estate, Inc.		\$ 100	\$ 100	1
2	V	30	Depreciation		Swansea Real Estate, Inc.		119,937	119,937	2
3	V	32	Interest		Swansea Real Estate, Inc.		1,135,438	1,135,438	3
4	V	34	Rent	1,156,600	Swansea Real Estate, Inc.			(1,156,600)	4
5	V								5
6	V								6
7	V								7
8	V	19	Professional Services	268,214	Claims Administration Services, LLC		107,828	(160,386)	8
9	V	20	Dues, Fees, & Subscriptions		Claims Administration Services, LLC		323	323	9
10	V	21	Clerical & General Office Expenses		Claims Administration Services, LLC		2,553	2,553	10
11	V	22	Payroll Taxes & Emp Benefits		Claims Administration Services, LLC		15,730	15,730	11
12	V	24	Travel & Seminar		Claims Administration Services, LLC		3,818	3,818	12
13	V	25	Other Admin Staff Transportation		Claims Administration Services, LLC		3,307	3,307	13
14	Total			\$ 1,424,814			\$ 1,389,034	\$ * (35,780)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	See Schedule VIII	\$ 9,600	HSM Management Services, Inc.		\$ 4,421	\$ (5,179)	15
16	V	5	See Schedule VIII		HSM Management Services, Inc.		326	326	16
17	V	6	See Schedule VIII		HSM Management Services, Inc.		11,535	11,535	17
18	V	17	See Schedule VIII	132,000	HSM Management Services, Inc.		46,066	(85,934)	18
19	V	19	See Schedule VIII		HSM Management Services, Inc.		34,380	34,380	19
20	V	21	See Schedule VIII	429,600	HSM Management Services, Inc.		169,163	(260,437)	20
21	V	22	See Schedule VIII		HSM Management Services, Inc.		18,924	18,924	21
22	V	24	See Schedule VIII		HSM Management Services, Inc.		3,957	3,957	22
23	V	25	See Schedule VIII		HSM Management Services, Inc.		2,232	2,232	23
24	V	26	See Schedule VIII		HSM Management Services, Inc.		1,776	1,776	24
25	V	30	See Schedule VIII		HSM Management Services, Inc.		6,777	6,777	25
26	V	34	See Schedule VIII		HSM Management Services, Inc.		21,895	21,895	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 571,200			\$ 321,452	\$ * (249,748)	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: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Administrative	0.00	0			Salary	\$ 82,460	17-1	1
2	Darrell Hoefling	Vice-President	Administrative	0.00	0			Salary	50,873	17-1	2
3											3
4	Larry Vander Maten	President	Administrative	0.00	26,244	4.83	8.06	Salary	2,300	17-8	4
5	Darrell Hoefling	Vice-President	Administrative	0.00	8,748	4.83	8.06	Salary	766	17-8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 136,399		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 Center Swansea# 0032680

Report Period Beginning:

07/01/2011Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

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	109,893,441	18	\$ 54,890	\$ 54,890	8,851,908	\$ 4,421	1
2	5	Utilities	Total Cost	109,893,441	18	4,044		8,851,908	326	2
3	6	Maintenance	Total Cost	109,893,441	18	143,203		8,851,908	11,535	3
4	17	Salaries - Officer	Total Cost	109,893,441	18	38,058	38,058	8,851,908	3,066	4
5	19	Professional Services	Total Cost	109,893,441	18	390,258		8,851,908	31,435	5
6	21	Salaries - Other	Total Cost	109,893,441	18	1,746,082	1,746,082	8,851,908	140,647	6
7	21	Clerical & Office Supplies	Total Cost	109,893,441	18	351,808		8,851,908	28,338	7
8	22	Payroll Taxes & Emp. Benefits	Total Cost	109,893,441	18	234,939		8,851,908	18,924	8
9	24	Travel & Seminar	Total Cost	109,893,441	18	46,889		8,851,908	3,777	9
10	25	Other Admin Transportation	Total Cost	109,893,441	18	27,706		8,851,908	2,232	10
11	26	Insurance	Total Cost	109,893,441	18	22,044		8,851,908	1,776	11
12	30	Depreciation	Total Cost	109,893,441	18	84,136		8,851,908	6,777	12
13	34	Building Rent	Total Cost	109,893,441	18	271,823		8,851,908	21,895	13
14	17	Direct-Admin	Direct Cost	1	1	62,000	62,000	0	0	14
15	17	Direct-Admin	Direct Cost	1	1	43,000	43,000	1	43,000	15
16	19	Professional Services	Direct Cost	1	1	2,945		1	2,945	16
17	21	Clerical & Office Supplies	Direct Cost	1	1	178		1	178	17
18	24	Travel & Seminar	Direct Cost	1	1	180		1	180	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,524,183	\$ 1,944,030		\$ 321,452	25

SEE ACCOUNTANTS' COMPILATION REPORT

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Loan Refinancing	\$85,143.00	10/26/99	\$ 10,237,500	\$ 8,669,248	11/2009	8.8900	\$ 1,135,438	1	
2	Add: Misc. Income Expense										472	2	
3	Less: Interest Income Offset										(3,894)	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			\$ 1,132,016	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			\$ 1,132,016	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.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 report.	\$	105,426	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.)	\$	42,869	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(62,557)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	129,053	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.	\$	66,496	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2007	76,246	8
	2008	74,507	9
	2009	72,259	10
	2010	62,881	11
	2011	65,275	12
<u>2010 Payment = \$32,394 + \$10,475 (Prior year adjustment to beginning accrual)</u>			
<u>Accrual = Remainder of 2010 tax bill (\$30,487) + 2011 tax bill (\$65,275) + 1/2 estimated</u>			
<u>2012 tax bill (\$33,291)</u>			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Rosewood Care Center Swansea</u>	COUNTY	<u>St. Clair</u>
---------------	-------------------------------------	--------	------------------

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314)994-9070 FAX #: (314)994-9112

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	08-09.0-402-023	Wandering Woods	\$ 65,275.38	\$ 65,275.38
2.		Lot/SEC-3 52855-554 & 3023-25	\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 65,275.38	\$ 65,275.38

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	6.8097 Acres	1987	\$ 126,031	1
2					2
3	TOTALS	#VALUE!		\$ 126,031	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	120			1987	\$ 2,175,969	\$	20-25	\$ 55,752	\$ 55,752	\$ 2,158,273	4	
5				1988	253,539		25	10,141	10,141	240,022	5	
6				1990	222,972		20-25	8,582	8,582	195,454	6	
7				1991	6,679		25	267	267	5,541	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	597	12	
13	Landscaping			1989	1,904		25	76	76	1,787	13	
14	Road			1990	431,970		25	17,279	17,279	380,136	14	
15	Parking Lot Expansion			1989	27,592		15			27,592	15	
16	Lawn Sprinkler System			1992	10,926		25	437	437	8,631	16	
17	Backflow for Sprinkler			1993	2,909		10	116	116	2,226	17	
18	Landscaping/Fencing			1987	25,279		25	1,011	1,011	25,023	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 Center Swansea

0032680

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	3,340	39
40	Roof Work	2004	21,620		40	541	541	4,325	40
41	Storage Building	2004	13,980		25	559	559	4,287	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	7,522	43
44	Fire Alarm System	2005	9,668		10	967	967	6,526	44
45	Satellite System	2006	9,002		10	900	900	5,626	45
46	Heat Pumps	2007	37,285		10	3,729	3,729	19,399	46
47	Evaporative Cooling Tower	2007	48,252		10	4,825	4,825	24,930	47
48	Water Heater	2007	3,545		10	354	354	1,713	48
49	Compressor Blower Motor	2007	2,938		10	294	294	1,445	49
50	Water Heater	2007	3,594		10	360	360	1,709	50
51	Electrical Wiring	2009	3,153		10	315	315	1,077	51
52	Painting Exterior of Building	2010	8,792		40	220	220	458	52
53	Heat Pumps	2009	6,327		10	633	633	1,688	53
54	Exterior Doors	2009	9,014		10	901	901	2,403	54
55	Wall Cabinets	2009	1,009		10	101	101	269	55
56	Sprinkler Pipe	2010	14,909		10	1,491	1,491	3,355	56
57	Water Heater	2010	4,040		10	404	404	875	57
58	Cooling Tower Fan	2011	4,554		10	455	455	493	58
59	Seal & Stripe Parking Lot	2010	4,839		25	194	194	323	59
60	Heat Pumps	2012	5,218		10	174	174	174	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)		\$ 3,571,135	\$		\$ 112,565	\$ 112,565	\$ 3,321,634	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:

07/01/2011

Ending:

06/30/2012

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		\$ 3,571,135	\$		\$ 112,565	\$ 112,565	\$ 3,321,634	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		7			3,554	21
22	Drywall	2004	6,594	236	7	236		6,594	22
23	Shelving	2004	2,271	81	7	81		2,271	23
24	Tile & Base 2 Rooms	2004	5,918	352	7	352		5,918	24
25	Floor Tile & Base	2005	4,203	600	7	600		4,003	25
26	Parking Lot Striping & Sealing	2005	3,993	570	7	570		3,803	26
27	Repair Water Damaged Rooms	2005	6,141	877	7	877		5,775	27
28	Drapes	2006	4,666	667	7	667		3,722	28
29	Carpet	2009	13,379	1,911	7	1,911		6,212	29
30	Water Heater	2011	4,780	569	7	569		569	30
31	Telephone System	2011	27,729	3,301	7	3,301		3,301	31
32	Cooling Tower Fan Motor Repair	2011	4,554	651	7	651		651	32
33	3 door freezer	2011	5,056	722	7	722		722	33
34	TOTAL (lines 1 thru 33)		\$ 3,799,618	\$ 10,537		\$ 123,102	\$ 112,565	\$ 3,504,374	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 126,092	\$	\$ 10,077	\$ 10,077	5-10 Yrs.	\$ 103,763	71
72	Current Year Purchases	7,412		768	768	5-10 Yrs.	768	72
73	Fully Depreciated Assets	508,559					508,559	73
74								74
75	TOTALS	\$ 642,063	\$	\$ 10,845	\$ 10,845		\$ 613,090	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	\$ 40,279	\$	\$ 3,304	\$ 3,304	4	\$ 21,643	76
77										77
78										78
79										79
80	TOTALS			\$ 40,279	\$	\$ 3,304	\$ 3,304		\$ 21,643	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)	\$ 4,607,991	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,537	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 137,251	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 126,714	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,139,107	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:
- *

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 Not Applicable		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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

HFS 3745 (N-4-99)

IL478-2471

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	hrs				2,106		2,106	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				345,744		345,744	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Physical, Occupational, & Speech Therapy Other (specify): Labs,X-Rays,Enterals	39,3				908,585			908,585	13
14	TOTAL			\$		\$ 908,585	\$ 347,850		\$ 1,256,435	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

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	\$ 409,516	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 203,404)	701,301		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,224		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,151,475	\$	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	298,158		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(252,414)		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)	\$ 48,211	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,199,686	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,017,959	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	300,851		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,945		31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,053		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(264,633)		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	1,367,201		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,578,376	\$	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)	\$ 2,578,376	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,378,690)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,199,686	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (574,034)	1
2	Restatements (describe):		2
3	Prior year adjustments to Income Tax, Management		3
4	Fees, & Real Estate Taxes	266,608	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (307,426)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,071,264)	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)	\$ (1,071,264)	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)	\$ (1,378,690)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680Report Period Beginning: 07/01/2011Ending: 06/30/2012

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

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,977,966	1
2	Discounts and Allowances for all Levels	(2,909,349)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,068,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,584,750	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,584,750	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	3,300	13
14	Non-Patient Meals	6,435	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)	\$ 9,735	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,894	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,894	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	7,296	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,674,292	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,249,269	31
32	Health Care	2,778,574	32
33	General Administration	2,989,553	33
	B. Capital Expense		
34	Ownership	1,248,031	34
	C. Ancillary Expense		
35	Special Cost Centers	1,480,129	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,745,556	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,071,264)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,071,264)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 362,026	44
45	Private Pay - Net Inpatient Revenue	3,582,776	45
46	Medicare - Net Inpatient Revenue	2,015,947	46
47	Other-(specify)	107,868	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,068,617	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,937	2,080	\$ 75,771	\$ 36.43	1
2	Assistant Director of Nursing	1,874	2,013	66,331	32.95	2
3	Registered Nurses	17,825	19,144	526,688	27.51	3
4	Licensed Practical Nurses	29,402	31,578	634,680	20.10	4
5	CNAs & Orderlies	75,618	81,214	829,564	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,709	7,205	134,028	18.60	8
9	Activity Director					9
10	Activity Assistants	5,265	5,655	52,607	9.30	10
11	Social Service Workers	4,200	4,511	64,864	14.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,833	23,449	228,015	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,022	2,171	32,851	15.13	17
18	Housekeepers	16,324	17,533	169,385	9.66	18
19	Laundry	5,534	5,944	52,459	8.83	19
20	Administrator	1,928	2,070	214,875	103.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,660	12,523	186,307	14.88	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	6,093	6,544	116,564	17.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,224	223,634	\$ 3,384,989 *	\$ 15.14	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	\$ 7,786	1,3	35
36	Medical Director	Contract	5,319	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,320	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)		\$ 23,225		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	465	\$ 18,148	10-3	50
51	Licensed Practical Nurses	1,754	50,864	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,219	\$ 69,012		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

0032680

Report Period Beginning:

07/01/2011

Page 21

Ending: 06/30/2012

Facility Name & ID Number

Rosewood Care Center Swansea

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Ken Kabureck</td> <td>Administrative</td> <td>0</td> <td>\$ 81,542</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Larry Vander Maten</td> <td>Administrative</td> <td>0</td> <td>82,460</td> </tr> <tr> <td>Darrell Hoefling</td> <td>Administrative</td> <td>0</td> <td>50,873</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 214,875</td> </tr> </table>				Name	Function	Ownership %	Amount	Ken Kabureck	Administrative	0	\$ 81,542					Larry Vander Maten	Administrative	0	82,460	Darrell Hoefling	Administrative	0	50,873									TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 214,875	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 115,763</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>80,108</td> </tr> <tr> <td>FICA Taxes</td> <td>235,401</td> </tr> <tr> <td>Employee Health Insurance</td> <td>52,019</td> </tr> <tr> <td>Employee Meals</td> <td></td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td></td> </tr> <tr> <td>Employee Relations</td> <td>2,109</td> </tr> <tr> <td>Employee Uniforms</td> <td>510</td> </tr> <tr> <td>Employee Physicals & Vaccinations</td> <td>2,554</td> </tr> <tr> <td>Related Party Allocation</td> <td>34,654</td> </tr> <tr> <td>Employee Drug Tests</td> <td>312</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 523,430</td> </tr> </table>			Description	Amount	Workers' Compensation Insurance	\$ 115,763	Unemployment Compensation Insurance	80,108	FICA Taxes	235,401	Employee Health Insurance	52,019	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Employee Relations	2,109	Employee Uniforms	510	Employee Physicals & Vaccinations	2,554	Related Party Allocation	34,654	Employee Drug Tests	312					TOTAL (agree to Schedule V, line 22, col.8)		\$ 523,430	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$ 1,990</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>2,898</td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed)</td> <td>3,865</td> </tr> <tr> <td>Patient Background Checks</td> <td></td> </tr> <tr> <td>IHCA Dues</td> <td>4,009</td> </tr> <tr> <td>Misc. Dues/Subscriptions</td> <td>1,099</td> </tr> <tr> <td>Promotional Advertising</td> <td>4,191</td> </tr> <tr> <td>Related Party Allocation</td> <td>323</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>Less: Public Relations Expense (</td> <td></td> </tr> <tr> <td>Non-allowable advertising</td> <td>(3,243)</td> </tr> <tr> <td>Yellow page advertising</td> <td>(948)</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 14,184</td> </tr> </table>		Description	Amount	IDPH License Fee	\$ 1,990	Advertising: Employee Recruitment	2,898	Health Care Worker Background Check (Indicate # of checks performed)	3,865	Patient Background Checks		IHCA Dues	4,009	Misc. Dues/Subscriptions	1,099	Promotional Advertising	4,191	Related Party Allocation	323			Less: Public Relations Expense (		Non-allowable advertising	(3,243)	Yellow page advertising	(948)	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,184
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B. Administrative - Other <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Bravo Nursing Home Services</td> <td>\$ 384,000</td> </tr> <tr> <td>Management Fees - HSM Management Services</td> <td>132,000</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td>\$ 516,000</td> </tr> </table>				Description	Amount	Bravo Nursing Home Services	\$ 384,000	Management Fees - HSM Management Services	132,000					TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 516,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees <table> <tr> <th>Description</th> <th>Line #</th> <th>Amount</th> </tr> <tr> <td>Section Not Applicable</td> <td></td> <td>\$</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2">TOTAL</td> <td>\$</td> </tr> </table>			Description	Line #	Amount	Section Not Applicable		\$																												TOTAL		\$	G. Schedule of Travel and Seminar** <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Out-of-State Travel</td> <td>\$</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>In-State Travel</td> <td>138</td> </tr> <tr> <td>Related Party Allocation</td> <td>7,775</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>Seminar Expense</td> <td>135</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>Entertainment Expense (</td> <td></td> </tr> <tr> <td colspan="2">(agree to Sch. V, line 24, col. 8)</td> <td></td> </tr> <tr> <td>TOTAL</td> <td>\$ 8,048</td> </tr> </table>		Description	Amount	Out-of-State Travel	\$					In-State Travel	138	Related Party Allocation	7,775					Seminar Expense	135					Entertainment Expense (		(agree to Sch. V, line 24, col. 8)			TOTAL	\$ 8,048														
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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

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 \$4,009
- (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.

\$ 64,228

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.

\$ 225,800

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.

\$ 6,435
- (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?

N/A

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.

\$ No
- (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 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
Attachment to Schedule XII D
Other Revenue
6/30/2012

Description		
28A	Vendor Discount	\$ 892
28B	Miscellaneous Income	5,563
28C	Vending Income	841
		<u>\$ 7,296</u>

Rosewood Care Center of Swansea
Attachment to Schedule XIX C
6/30/2012

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
C.J. Schlosser & Company	Accountant/Consultant	4,079
Claims Administration Services, Inc.	Related Party Legal Fees	268,214
Suzanne Koenig, Receiver	Receiver & Bankruptcy Court Fees	294,715
Atkinson-Baker, Inc	Deposition Transcription	786 *
Becker Paulson Hoerner & Thompson	Out-of-period Fees	1,019 *
Becker, Paulson, Hoerner & Thompson, PC	Allowable Legal Fees	3,212
Brian T McCarthy, Attorney at Law	Out-of-period Fees	330 *
Charles W Riske, Attorney at Law	Allowable Legal Fees	570
Clerk of the Appellate Court	Court Fees	25
CliftonLarsonAllen	Legal Consultant	3,539
Daniel Maher	Collections & Out-of-period Fees	1,214 *
Daniel Maher	Allowable Legal Fees	1,494
Desa Eggman Mason LLC	Allowable Legal Fees	12,312
Donna F. Loepker, CSR, RPR	Transcription Fee	1,784
Doster Ullom, LLC	Allowable Legal Fees	19,025
Doster Ullom, LLC	Out-of-period Fees	7,450 *
Eldercare Decisions, Inc.	Review Fees	4,310 *
Karen D. Chatham, CSR	Deposition Transcription	2,604
Kuehn Law Firm	Allowable Legal Fees	63,811
Kuehn Law Firm	Out-of-period Fees	7,792 *
Marsh USA	Bond Renewal	100
Midwest Trial Services	Trial Expenses	254 *
Miles Reporting Company	Deposition Transcription	91
Rosewood Holding Company	Related Party Legal Fees	5,400 *
SJM & Co., Inc.	Business Services	1,901
SJM & Co., Inc.	Out-of-period Fees	195 *
St. Clair County Circuit Court	Court Fees	676
St. Clair County Circuit Court	Out-of-period Fees	58 *
Steven Hamburg, PC	Allowable Legal Fees	54,171
Summers Compton Wells	Allowable Legal Fees	13,002
Summers Compton Wells	Out-of-period Fees	898 *
Tellatin, Short & Hansen, Inc.	Legal Consultant	2,450
Zimmerman, Kiser & Sutcliffe, P.A.	Allowable Legal Fees	8,004

785,485

Invoices Disallowed for Cost Reporting purposes due to cost being out-of-period
or for unallowable purposes

* 29,706