

Facility Name & ID Number Rosewood Care Center Swansea

0032680 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</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>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF			<u>12,404</u>	<u>12,404</u>	8
9	SNF/PED					9
10	ICF	<u>2,966</u>	<u>21,148</u>		<u>24,114</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,966</u>	<u>21,148</u>	<u>12,404</u>	<u>36,518</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.37%

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

44 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 10/8/1987

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

YES Date 10/8/1987 NO

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

YES NO If YES, enter number of beds certified 39 and days of care provided 12,404

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2005 Fiscal Year: 6/30/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	198,620	20,308	8,441	227,369		227,369		227,369		1
2	Food Purchase		160,023		160,023		160,023	(7,378)	152,645		2
3	Housekeeping	119,468	31,533		151,001		151,001		151,001		3
4	Laundry	43,058	17,388		60,446		60,446		60,446		4
5	Heat and Other Utilities			139,711	139,711		139,711	5	139,716		5
6	Maintenance	27,248	7,693	82,738	117,679		117,679	15,330	133,009		6
7	Other (specify):* Sanitation			10,748	10,748		10,748		10,748		7
8	TOTAL General Services	388,394	236,945	241,638	866,977		866,977	7,957	874,934		8
	B. Health Care and Programs										
9	Medical Director			3,969	3,969		3,969		3,969		9
10	Nursing and Medical Records	1,853,686	171,987		2,025,673		2,025,673		2,025,673		10
10a	Therapy	75,524	4,024	615,791	695,339		695,339	(63,221)	632,118		10a
11	Activities	54,929	4,898	2,400	62,227		62,227		62,227		11
12	Social Services	49,176	50	2,400	51,626		51,626		51,626		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,033,315	180,959	624,560	2,838,834		2,838,834	(63,221)	2,775,613		16
	C. General Administration										
17	Administrative			981,700	981,700		981,700	(814,864)	166,836		17
18	Directors Fees										18
19	Professional Services			3,885	3,885		3,885	34,463	38,348		19
20	Dues, Fees, Subscriptions & Promotions			20,170	20,170		20,170	(9,061)	11,109		20
21	Clerical & General Office Expenses	146,305	40,827	12,825	199,957		199,957	150,956	350,913		21
22	Employee Benefits & Payroll Taxes			317,019	317,019		317,019	28,968	345,987		22
23	Inservice Training & Education										23
24	Travel and Seminar			283	283		283		283		24
25	Other Admin. Staff Transportation			10,393	10,393		10,393	15,249	25,642		25
26	Insurance-Prop.Liab.Malpractice			63,144	63,144		63,144	16,723	79,867		26
27	Other (specify):*										27
28	TOTAL General Administration	146,305	40,827	1,409,419	1,596,551		1,596,551	(577,566)	1,018,985		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,568,014	458,731	2,275,617	5,302,362		5,302,362	(632,830)	4,669,532		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Rosewood Care Center Swansea

#0032680

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,169	18,169		18,169	167,791	185,960			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							789,777	789,777			32
33	Real Estate Taxes			75,526	75,526		75,526		75,526			33
34	Rent-Facility & Grounds			1,458,718	1,458,718		1,458,718	(1,446,357)	12,361			34
35	Rent-Equipment & Vehicles			27,767	27,767		27,767		27,767			35
36	Other (specify):*											36
37	TOTAL Ownership			1,580,180	1,580,180		1,580,180	(488,789)	1,091,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		281,614	57,029	338,643		338,643		338,643			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		281,614	122,729	404,343		404,343		404,343			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,568,014	740,345	3,978,526	7,286,885		7,286,885	(1,121,619)	6,165,266			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,919)	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	(7,920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(459)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,273)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,210)	20		28
29	Other-Attach Schedule Marketing Salary	(56,318)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (81,099)		\$	30

OHF 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)	(1,040,520)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,040,520)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,121,619)		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	Exceptional Care Program		X		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: 7/1/2004

Ending: 6/30/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (56,318)	21
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49	Total	(56,318)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

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	(7,378)	0	0	0	0	0	0	0	0	0	0	(7,378)	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	5	0	0	0	0	0	0	0	0	5	5
6	Maintenance	0	0	15,330	0	0	0	0	0	0	0	0	15,330	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,378)	0	15,335	0	7,957	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	(63,221)	0	0	0	0	0	0	0	0	0	(63,221)	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	(63,221)	0	0	0	0	0	0	0	0	0	(63,221)	16
	C. General Administration													
17	Administrative	0	(981,700)	166,836	0	0	0	0	0	0	0	0	(814,864)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	34,463	0	0	0	0	0	0	0	0	34,463	19
20	Fees, Subscriptions & Promotions	(9,483)	0	422	0	0	0	0	0	0	0	0	(9,061)	20
21	Clerical & General Office Expenses	(56,318)	0	207,274	0	0	0	0	0	0	0	0	150,956	21
22	Employee Benefits & Payroll Taxes	0	0	28,968	0	0	0	0	0	0	0	0	28,968	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	15,249	0	0	0	0	0	0	0	0	15,249	25
26	Insurance-Prop.Liab.Malpractice	0	6,659	10,064	0	0	0	0	0	0	0	0	16,723	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(65,801)	(975,041)	463,276	0	(577,566)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,179)	(1,038,262)	478,611	0	(632,830)	29							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management Fee	\$ 981,700	HSM Management Services, Inc.	100.00%	\$	\$ (981,700)
2	V						2
3	V	10a Therapy	615,791	Rosewood Therapy Service, Inc.	0.00%	552,570	(63,221)
4	V						4
5	V	34 Rent	1,458,718	Swansea Real Estate, Co., Inc.	0.00%		(1,458,718)
6	V	30 Depreciation		Swansea Real Estate, Co., Inc.	0.00%	148,964	148,964
7	V	32 Interest		Swansea Real Estate, Co., Inc.	0.00%	797,697	797,697
8	V	26 Property Insurance		Swansea Real Estate, Co., Inc.	0.00%	6,659	6,659
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 3,056,209			\$ 1,505,890	\$ * (1,550,319)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 166,836	\$ 166,836
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	207,274	207,274
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	28,968	28,968
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	15,249	15,249
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	18,827	18,827
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	12,361	12,361
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	34,463	34,463
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,064	10,064
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	15,330	15,330
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	5	5
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	422	422
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 509,799	\$ * 509,799

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

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

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	Management	75.00%	1,145,993	2	6.12%	Salary	\$ 74,737	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	471,549	2	6.12%	Salary	30,753	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	\$ 105,490		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: 7/1/2004 Ending: 7/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

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	17	Salaries - Officers	Total Cost	87,014,347	18	\$ 1,723,032	\$ 5,327,317	\$ 105,490	1
2	21	Salaries - Others	Total Cost	87,014,347	18	2,976,309	5,327,317	182,220	2
3	22	Payroll Taxes	Total Cost	87,014,347	18	298,975	5,327,317	18,304	3
4	22	Employee Benefits	Total Cost	87,014,347	18	103,243	5,327,317	6,321	4
5	25	Travel	Total Cost	87,014,347	18	249,076	5,327,317	15,249	5
6	30	Depreciation	Total Cost	87,014,347	18	307,518	5,327,317	18,827	6
7	34	Building Rent	Total Cost	87,014,347	18	201,898	5,327,317	12,361	7
8	19	Professional Services	Total Cost	87,014,347	18	562,909	5,327,317	34,463	8
9	21	Telephone	Total Cost	87,014,347	18	173,318	5,327,317	10,611	9
10	26	Insurance	Total Cost	87,014,347	18	164,374	5,327,317	10,064	10
11	21	Taxes, Licenses, Ofc Sup	Total Cost	87,014,347	18	235,903	5,327,317	14,443	11
12	6	Maintenance	Total Cost	87,014,347	18	157,822	5,327,317	9,662	12
13	5	Heat & Other Utilities	Total Cost	87,014,347	18	77	5,327,317	5	13
14	20	Dues & Subscriptions	Total Cost	87,014,347	18	6,896	5,327,317	422	14
15	17	Direct - Admin	Direct Cost	1	1	61,346	1	61,346	15
16	17	Direct - Admin	Direct Cost	17	17	1,094,600	1,094,600	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,343	1	4,343	17
18	22	Direct - Payroll Taxes	Direct Cost	17	17	78,379	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	0	0	1	0	19
20	30	Direct - Depreciation	Direct Cost	2	2	1,050	0	0	20
21	25	Direct - Travel	Direct Cost	1	0	0	1	0	21
22	25	Direct - Travel	Direct Cost	6	6	1,048	0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	5,668	1	5,668	23
24	6	Direct - Maintenance	Direct Cost	14	14	225,743	0	0	24
25	TOTALS					\$ 8,633,527	\$ 5,855,287	\$ 509,799	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Loan Refinancing	\$85,143.00	10/26/99	\$ 10,237,500	\$ 9,526,212	11/2009	8.89%	\$ 865,304	1
2	Amortization of Loan Costs										14,015	2
3	Less: Related Party Interest Income Offset										(78,027)	3
4	Less: Interest Income Offset										(7,920)	4
5	Real Estate Company Interest Income										(3,595)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$85,143.00		\$ 10,237,500	\$ 9,526,212			\$ 789,777	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	\$ 9,526,212			\$ 789,777	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

Facility Name & ID Number **Rosewood Care Center Swansea**# **0032680** Report Period Beginning: **7/1/2004** Ending: **6/30/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	65,950	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.)				\$	68,684	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	2,734	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	72,792	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.				\$	75,526	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2000	68,687	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2001	64,896	9																						
	2002	62,589	10																						
	2003	65,297	11																						
	2004	72,071	12																						
2003 Payment = \$32,649																									
2004 Payment = \$36,035																									
Accrual = Balance of 2004 tax bill (36,036) + 1/2 of estimated 2005 tax bill (36,756)																									

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Swansea COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-09.0-402-023</u>	<u>LOT/SEC 3 BK 2855-554 & 3023-25</u>	<u>\$ 72,070.90</u>	<u>\$ 72,070.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 72,070.90</u>	<u>\$ 72,070.90</u>

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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Rosewood Care Center Swansea# 0032680 Report Period Beginning:7/1/2004 Ending:6/30/2005

X. BUILDING AND GENERAL INFORMATION:

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

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>6.8097 Acres</u>	<u>1987</u>	<u>\$ 126,031</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	6.8097 Acres		\$ 126,031	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680

Report Period Beginning:

7/1/2004

Ending:

6/30/2005**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF 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	\$ 94,861	\$ 94,861	\$ 1,680,019	4
5			1988	253,539		25	10,141	10,141	169,031	5
6			1990	222,972		5--25	8,582	8,582	135,377	6
7			1991	6,679		25	267	267	3,671	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	423	12
13	Landscaping		1989	1,904		25	76	76	1,254	13
14	Road		1990	431,970		25	17,279	17,279	259,185	14
15	Parking Lot Expansion		1989	27,592		15			27,592	15
16	Lawn Sprinkler System		1992	10,926		25	437	437	5,572	16
17	Backflow for Sprinkler		1993	2,909		25	116	116	1,411	17
18	Landscape/Fencing		1987	25,279		25	1,011	1,011	17,945	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 System		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 Guards		1989	5,509		10			5,509	35
36	Corner Guards		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:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Carpeting	1990	\$ 2,215	\$	10	\$	\$	\$ 2,215		37
38	Hot Water Storage Tank	1996	2,607		10	261	261	2,240		38
39	Heat Pumps	2003	3,746		10	375	375	718		39
40	Roof Work	2004	21,620		40	540	540	540		40
41	Storage Building	2004	13,980		25	373	373	373		41
42	Parking Lot Seal & Stripe	2004	3,993		2	1,664	1,664	1,664		42
43										43
44										44
45										45
46	Leasehold Improvements - Facility:									46
47	Carpet/Tile/Painting - Nurse Call Station	1993	20,471		7			20,471		47
48	Painting/Wallpaper	1994	15,422		7			15,422		48
49	Painting/Wallpaper/Tile	1995	25,375		7			25,375		49
50	Shelving	1995	2,186		7			2,186		50
51	New Upholstery	1995	513		7			513		51
52	Design Work	1995	128		7			128		52
53	Carpeting	1996	5,580		7			5,580		53
54	Painting/Tiling	1996	6,383		7			6,383		54
55	Painting	1997	3,025	35	7	35		3,025		55
56	Tile & Base 2 Rooms	1997	1,400	17	7	17		1,400		56
57	2 Oak Doors	1997	803	19	7	19		803		57
58	Carpet & Installation	1998	7,951	662	7	662		7,951		58
59	Shower Renovations	1998	16,869	1,505	7	1,505		16,869		59
60	Paint/Wallpaper/Tile Removal	1998	1,833	211	7	211		1,833		60
61	Shower Room	1998	18,424	2,632	7	2,632		18,095		61
62	Wallpaper	1999	273	39	7	39		247		62
63	Painting	1998	970	115	7	115		970		63
64	Wallpaper	1998	5,103	668	7	668		5,103		64
65	Carpet/Installation	1998	5,106	671	7	671		5,106		65
66	Phone System	1998	8,703	1,244	7	1,244		8,554		66
67	Wallpaper	1998	4,450	635	7	635		4,411		67
68	Drapery	2000	31,964	4,567	7	4,567		24,635		68
69	Computer Cabling	2000	2,392	341	7	341		1,565		69
70	TOTAL (lines 4 thru 69)		\$ 3,499,770	\$ 13,361		\$ 149,369	\$ 136,008	\$ 2,591,780		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/2004

Ending:

Page 12B

6/30/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward								
2	2001	18,240	2,606	7	2,606		11,627		2
3	2001	606	87	7	87		347		3
4	2002	1,150	164	7	164		424		4
5	2004	3,554	508	7	508		846		5
6	2004	6,594	707	7	707		707		6
7	2004	2,271	243	7	243		243		7
8	2004	5,918	493	7	493		493		8
9									9
10									10
11									11
12									12
13									13
14									14
15	Leasehold Improvements - Management Company:								
16	1995	469		5			469		16
17	1995	43		5			43		17
18	1996	100		4			100		18
19	1996	442		4			442		19
20	1997	1,185		3			1,185		20
21	1998	668		3			668		21
22	1999	330		3			330		22
23	1999	165		3			165		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)		\$ 3,541,505	\$ 18,169		\$ 154,177	\$ 136,008	\$ 2,609,869	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 Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 180,658	\$	\$ 21,773	\$ 21,773	5-10 Yrs	\$ 114,364	71
72	Current Year Purchases	36,556		1,313	1,313	5-10 Yrs	1,313	72
73	Fully Depreciated Assets	488,777					488,777	73
74								74
75	TOTALS	\$ 705,991	\$	\$ 23,086	\$ 23,086		\$ 604,454	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 39,129	\$	\$ 8,697	\$ 8,697	4 Yrs	\$ 17,927	76
77										77
78										78
79										79
80	TOTALS			\$ 39,129	\$	\$ 8,697	\$ 8,697		\$ 17,927	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)	\$ 4,412,656	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,169	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,960	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 167,791	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,232,250	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.

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

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. /2006 \$

13. /2007 \$

14. /2008 \$

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			\$	\$	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.

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)			
			Staff		Outside Practitioner (other than consultant)									
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-8	hrs	\$	21,380	\$	205,586	\$	21,380	\$	205,586	1		
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,341		41,058		2,341		41,058	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a-8	hrs		31,016		305,926		4,024		31,016	309,950	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-8	# of prescripts						255,536			255,536	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Ambulance, Laboratory, Enterals, Other (specify): & X-Ray	39-8					57,029		26,078			83,107	13	
14	TOTAL			\$	54,737	\$	609,599	\$	285,638		54,737	\$	895,237	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning: 7/1/2004

Ending:

6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2005

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ (58,399)	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,000)	959,998	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	15,485	6
7	Other Prepaid Expenses	3,613	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 920,697	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	223,657	15
16	Equipment, at Historical Cost		16
17	Accumulated Depreciation (book methods)	(191,310)	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):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,347	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 953,044	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 429,279	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	175,060	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,517	31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,792	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes	58,300	35
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 756,948	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)	\$ 756,948	46
47	TOTAL EQUITY (page 18, line 24)	\$ 196,096	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 953,044	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 186,189	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 186,189	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	289,107	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	(279,200)	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)	\$ 9,907	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)	\$ 196,096	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning: 7/1/2004

Ending:

6/30/2005

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,823,626	1
2	Discounts and Allowances for all Levels	(2,867,345)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,956,281	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,778,255	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,778,255	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	6,919	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)	\$ 10,219	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,920	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,920	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	517	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 517	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,753,192	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	866,977	31
32	Health Care	2,838,834	32
33	General Administration	1,596,551	33
B. Capital Expense			
34	Ownership	1,580,180	34
C. Ancillary Expense			
35	Special Cost Centers	338,643	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,286,885	40
41	Income before Income Taxes (line 30 minus line 40)**	466,307	41
42	Income Taxes	(177,200)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 289,107	43

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

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

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

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

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

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	2,034	2,163	\$ 63,705	\$ 29.45	1
2	Assistant Director of Nursing	2,017	2,145	56,673	26.42	2
3	Registered Nurses	15,341	16,317	354,040	21.70	3
4	Licensed Practical Nurses	30,530	32,473	578,251	17.81	4
5	CNAs & Orderlies	68,879	73,261	717,232	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,020	5,340	75,524	14.14	8
9	Activity Director					9
10	Activity Assistants	5,309	5,647	54,929	9.73	10
11	Social Service Workers	4,076	4,335	49,176	11.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,253	21,542	198,620	9.22	15
16	Dishwashers					16
17	Maintenance Workers	2,174	2,313	27,248	11.78	17
18	Housekeepers	14,804	15,746	119,468	7.59	18
19	Laundry	5,816	6,186	43,058	6.96	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,477	12,207	146,305	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,950	6,328	83,785	13.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,680	206,003	\$ 2,568,014 *	\$ 12.47	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	365	\$ 8,441	1-3	35
36	Medical Director	Contract	3,969	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	80	2,400	11-3	44
45	Social Service Consultant	80	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	525	\$ 17,210		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680Report Period Beginning: 7/1/2004Ending: 6/30/2005**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 - \$6,293
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,224 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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,919
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF SWANSEA, INC.
IDPH ID #0032680
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2005

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 10,393</u>
	<u><u>\$ 10,393</u></u>

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH

ROSEWOOD CARE CENTER OF SWANSEA, INC.
IDPH ID #0032680
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2005

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
SWANSEA REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY