



Facility Name & ID Number Rosewood Care Center Swansea

# 0032680 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	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			
9	SNF/PED					9
10	ICF					10
11	ICF/DD	2,743	22,267		25,010	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,743	22,267	12,242	37,252	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.82%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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 48 and days of care provided 12,242

Medicare Intermediary TriSpan Health Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/07 Ending: 6/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
<b>A. General Services</b>											
1	Dietary	209,109	20,527	7,906	237,542		237,542	2,992	240,534		1
2	Food Purchase		180,169		180,169		180,169	(6,265)	173,904		2
3	Housekeeping	146,186	32,625		178,811		178,811		178,811		3
4	Laundry	43,179	18,084		61,263		61,263		61,263		4
5	Heat and Other Utilities			178,856	178,856		178,856	233	179,089		5
6	Maintenance	30,255	18,021	91,321	139,597		139,597	12,777	152,374		6
7	Other (specify):* <b>Garbage Collection</b>			10,333	10,333		10,333		10,333		7
8	<b>TOTAL General Services</b>	428,729	269,426	288,416	986,571		986,571	9,737	996,308		8
<b>B. Health Care and Programs</b>											
9	Medical Director			12,094	12,094		12,094		12,094		9
10	Nursing and Medical Records	2,119,768	199,102	49,510	2,368,380		2,368,380		2,368,380		10
10a	Therapy	94,610	7,380	629,535	731,525		731,525	139,896	871,421		10a
11	Activities	54,428	4,704	2,550	61,682		61,682		61,682		11
12	Social Services	52,371		2,550	54,921		54,921		54,921		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,321,177	211,186	696,239	3,228,602		3,228,602	139,896	3,368,498		16
<b>C. General Administration</b>											
17	Administrative	79,964		2,017,588	2,097,552		2,097,552	(2,009,296)	88,256		17
18	Directors Fees										18
19	Professional Services			47,372	47,372		47,372	5,719	53,091		19
20	Dues, Fees, Subscriptions & Promotions			41,877	41,877		41,877	(26,228)	15,649		20
21	Clerical & General Office Expenses	160,111	26,945	10,520	197,576		197,576	112,131	309,707		21
22	Employee Benefits & Payroll Taxes			401,151	401,151		401,151	18,728	419,879		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,428	4,428		4,428	3,563	7,991		24
25	Other Admin. Staff Transportation			8,131	8,131		8,131	3,603	11,734		25
26	Insurance-Prop.Liab.Malpractice			82,651	82,651		82,651	5,463	88,114		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	240,075	26,945	2,613,718	2,880,738		2,880,738	(1,886,317)	994,421		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,989,981	507,557	3,598,373	7,095,911		7,095,911	(1,736,684)	5,359,227		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 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	
	<b>D. Ownership</b>											
30	Depreciation			6,935	6,935		6,935	141,118	148,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,324	20,324		20,324	809,417	829,741			32
33	Real Estate Taxes			77,967	77,967		77,967		77,967			33
34	Rent-Facility & Grounds			1,503,092	1,503,092		1,503,092	(1,486,498)	16,594			34
35	Rent-Equipment & Vehicles			47,194	47,194		47,194		47,194			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,655,512	1,655,512		1,655,512	(535,963)	1,119,549			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		302,007	61,029	363,036		363,036		363,036			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		302,007	126,909	428,916		428,916		428,916			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,989,981	809,564	5,380,794	9,180,339		9,180,339	(2,272,647)	6,907,692			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: 7/1/07

Ending: 6/30/08

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	(5,732)	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	(3,367)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(533)	2		13
14	Non-Care Related Interest	(20,324)	32		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	(6,000)	19		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,228)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,401)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(5,827)	20		29
29	Other-Attach Schedule	(65,195)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (131,607)		\$	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)	(2,141,040)	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,141,040)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,272,647)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Swansea

ID# 0032680

Report Period Beginning: 7/1/07

Ending: 6/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (65,195)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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	<b>Total</b>	(65,195)		48
49				49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Swansea# 0032680 Report Period Beginning:7/1/07Ending: 6/30/08**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	2,992	0	0	0	0	0	0	0	0	2,992	1
2	Food Purchase	(6,265)	0	0	0	0	0	0	0	0	0	0	(6,265)	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	233	0	0	0	0	0	0	0	0	233	5
6	Maintenance	0	0	9,883	2,894	0	0	0	0	0	0	0	12,777	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,265)</b>	<b>0</b>	<b>13,108</b>	<b>2,894</b>	<b>0</b>	<b>9,737</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
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	139,896	0	0	0	0	0	0	0	0	0	139,896	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>139,896</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>139,896</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(2,017,588)	8,292	0	0	0	0	0	0	0	0	(2,009,296)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,228)	0	15,947	0	0	0	0	0	0	0	0	5,719	19
20	Fees, Subscriptions & Promotions	(26,228)	0	0	0	0	0	0	0	0	0	0	(26,228)	20
21	Clerical & General Office Expenses	(65,195)	0	177,303	23	0	0	0	0	0	0	0	112,131	21
22	Employee Benefits & Payroll Taxes	0	0	18,620	108	0	0	0	0	0	0	0	18,728	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,496	67	0	0	0	0	0	0	0	3,563	24
25	Other Admin. Staff Transportation	0	0	3,482	121	0	0	0	0	0	0	0	3,603	25
26	Insurance-Prop.Liab.Malpractice	0	2,410	3,009	44	0	0	0	0	0	0	0	5,463	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(101,651)</b>	<b>(2,015,178)</b>	<b>230,149</b>	<b>363</b>	<b>0</b>	<b>(1,886,317)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(107,916)</b>	<b>(1,875,282)</b>	<b>243,257</b>	<b>3,257</b>	<b>0</b>	<b>(1,736,684)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Swansea

# 0032680

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	0	128,894	12,178	46	0	0	0	0	0	0	0	141,118 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(23,691)	833,108	0	0	0	0	0	0	0	0	0	809,417 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(1,503,092)	16,594	0	0	0	0	0	0	0	0	(1,486,498) 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	<b>TOTAL Ownership</b>	<b>(23,691)</b>	<b>(541,090)</b>	<b>28,772</b>	<b>46</b>	<b>0</b>	<b>(535,963) 37</b>						
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(131,607)</b>	<b>(2,416,372)</b>	<b>272,029</b>	<b>3,303</b>	<b>0</b>	<b>(2,272,647) 45</b>						

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	\$ 1,325,893	HSM Management Services, Inc.		\$	(1,325,893) 1
2	V	17 Administrative Fee	691,695	Midwest Administrative Services, Inc.			(691,695) 2
3	V						
4	V	10a Therapy	629,535	Rosewood Therapy Services, Inc.		769,431	139,896 4
5	V						
6	V	34 Rent	1,503,092	Swansea Real Estate, Inc.			(1,503,092) 6
7	V	30 Depreciation		Swansea Real Estate, Inc.		128,894	128,894 7
8	V	32 Interest		Swansea Real Estate, Inc.		833,108	833,108 8
9	V	26 Property Insurance		Swansea Real Estate, Inc.		2,410	2,410 9
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 4,150,215			\$ 1,733,843	\$ * (2,416,372) 14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19	See Schedule VIII	\$	HSM Management Services, Inc.		\$ 84	\$ 84	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.		38,207	38,207	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.		3,324	3,324	17
18	V	24	See Schedule VIII		HSM Management Services, Inc.		2,061	2,061	18
19	V	25	See Schedule VIII		HSM Management Services, Inc.		1,684	1,684	19
20	V	26	See Schedule VIII		HSM Management Services, Inc.		1,030	1,030	20
21	V								21
22	V								22
23	V	1	See Schedule VIII		Midwest Administrative Services, Inc.		2,992	2,992	23
24	V	5	See Schedule VIII		Midwest Administrative Services, Inc.		233	233	24
25	V	6	See Schedule VIII		Midwest Administrative Services, Inc.		9,883	9,883	25
26	V	17	See Schedule VIII		Midwest Administrative Services, Inc.		8,292	8,292	26
27	V	19	See Schedule VIII		Midwest Administrative Services, Inc.		15,863	15,863	27
28	V	21	See Schedule VIII		Midwest Administrative Services, Inc.		139,096	139,096	28
29	V	22	See Schedule VIII		Midwest Administrative Services, Inc.		15,296	15,296	29
30	V	24	See Schedule VIII		Midwest Administrative Services, Inc.		1,435	1,435	30
31	V	25	See Schedule VIII		Midwest Administrative Services, Inc.		1,798	1,798	31
32	V	26	See Schedule VIII		Midwest Administrative Services, Inc.		1,979	1,979	32
33	V	30	See Schedule VIII		Midwest Administrative Services, Inc.		12,178	12,178	33
34	V	34	See Schedule VIII		Midwest Administrative Services, Inc.		16,594	16,594	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 272,029	\$ * 272,029	39

\* 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: 7/1/07 Ending: 6/30/08

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	6 Repairs & Maintenance	\$	Senior Living Services		\$ 2,894	\$ 2,894	15
16	V	21 Clerical & Office Expenses		Senior Living Services		23	23	16
17	V	22 Payroll Taxes & Emp Benefits		Senior Living Services		108	108	17
18	V	24 Travel & Seminar		Senior Living Services		67	67	18
19	V	25 Other Admin Staff Transportation		Senior Living Services		121	121	19
20	V	26 Insurance		Senior Living Services		44	44	20
21	V	30 Depreciation		Senior Living Services		46	46	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$ 3,303	\$ * 3,303	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Rosewood Care Center Swansea      #      0032680      Report Period Beginning:      7/1/07      Ending:      6/30/08

## 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	80,743	2.51	6.27	Salary	\$ 5,400	17-8	1
2	Darrel Hoefling	Vice President	Management	25.00	43,250	2.51	6.27	Salary	2,893	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	\$ 8,293		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: 7/1/07 Ending: 6/30/08

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2	19 Professional Services	Total Cost	46,341,843	18	1,305		2,997,496	84	2
3	21 Salaries - Other	Total Cost	46,341,843	18	577,445	577,445	2,997,496	37,350	3
4	21 Taxes, Licenses & Office Sup	Total Cost	46,341,843	18	13,251		2,997,496	857	4
5	22 Payroll Taxes	Total Cost	46,341,843	18	34,692		2,997,496	2,244	5
6	22 Employee Benefits	Total Cost	46,341,843	18	16,704		2,997,496	1,080	6
7	24 Travel & Seminar	Total Cost	46,341,843	18	31,856		2,997,496	2,061	7
8	25 Other Admin Staff Transp	Total Cost	46,341,843	18	26,039		2,997,496	1,684	8
9	26 Insurance	Total Cost	46,341,843	18	15,926		2,997,496	1,030	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 717,218	\$ 577,445		\$ 46,390	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/07 Ending: 6/30/08

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 Midwest Administrative 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost	18	\$ 47,734	\$ 47,734	5,962,410	\$ 2,992	1
2	5	Utilities	Total Cost	18	3,721		5,962,410	233	2
3	6	Maintenance	Total Cost	18	157,666		5,962,410	9,883	3
4	17	Salaries - Officers	Total Cost	18	132,286	132,286	5,962,410	8,292	4
5	19	Professional Services	Total Cost	18	253,059		5,962,410	15,863	5
6	21	Salaries - Other	Total Cost	18	1,781,817	1,781,817	5,962,410	111,695	6
7	21	Clerical & Office Supplies	Total Cost	18	437,110		5,962,410	27,401	7
8	22	Payroll Taxes & Emp Bene	Total Cost	18	244,016		5,962,410	15,296	8
9	24	Travel & Seminar	Total Cost	18	22,893		5,962,410	1,435	9
10	25	Other Admin Transp	Total Cost	18	28,676		5,962,410	1,798	10
11	26	Insurance	Total Cost	18	31,565		5,962,410	1,979	11
12	30	Depreciation	Total Cost	18	172,574		5,962,410	10,818	12
13	34	Building Rent	Total Cost	18	264,718		5,962,410	16,594	13
14	17	Direct - Admin	Direct Cost	1			1		14
15	17	Direct - Admin	Direct Cost	17	107,457	107,457			15
16	30	Direct - Depreciation	Direct Cost	1	1,360		1	1,360	16
17	30	Direct - Depreciation	Direct Cost	17	20,220				17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,706,872	\$ 2,069,294		\$ 225,639	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/07 Ending: 6/30/08

**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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Bank of America		X	Loan Refinancing	\$85,143.00	10/26/99	\$ 10,237,500	\$ 8,969,388	11/2009	8.8900	\$ 819,243	1
2	Amortization of Loan Costs										13,865	2
3	Less: Interest Income Offset										(3,367)	3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$85,143.00		\$ 10,237,500	\$ 8,969,388			\$ 829,741	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 10,237,500	\$ 8,969,388			\$ 829,741	15

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

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

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

Facility Name & ID Number **Rosewood Care Center Swansea**# **0032680** Report Period Beginning: **7/1/07** Ending: **6/30/08****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2007 report.			\$	<b>111,187</b>	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.)			\$	<b>73,634</b>	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	<b>(37,553)</b>	3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>115,520</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>77,967</b>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2003	<b>65,297</b>	8	<b>FOR BHF USE ONLY</b>	
		2004	<b>72,071</b>	9	13	FROM R. E. TAX STATEMENT FOR 2007 \$ 13
		2005	<b>74,939</b>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2006	<b>73,634</b>	11	15	LESS REFUND FROM LINE 6 \$ 15
		2007	<b>76,246</b>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>2006 Payment = \$73,634</b>						
<b>Accrual = 2007 tax bill (\$76,246) + 1/2 of the estimated 2008 tax bill (\$39,274)</b>						

**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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 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,

**2007 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 Costs**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 08-09-0-402-023	Wandering Woods	\$ 76,246.22	\$ 76,246.22
2. _____	LOT/SEC-3 BK 52855-554 & 3023-2	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>76,246.22</u>	\$ <u>76,246.22</u>

**B. Real Estate Tax Cost Allocation:**

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

**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 ground (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	<u>Nursing Home</u>	<u>6.8097 Acres</u>	<u>1987</u>	<u>\$ 126,031</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 126,031</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rosewood Care Center Swansea

# 0032680

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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 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	\$ 65,528	\$ 65,528	\$ 1,935,267	4
5			1988	253,539		25	10,141	10,141	199,456	5
6			1990	222,972		20-25	8,582	8,582	161,125	6
7			1991	6,679		25	267	267	4,473	7
8										8
<b>Improvement Type**</b>										
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	497	12
13	Landscaping		1989	1,904		25	76	76	1,483	13
14	Road		1990	431,970		25	17,279	17,279	311,021	14
15	Parking Lot Expansion		1989	27,592		15			27,592	15
16	Lawn Sprinkler System		1992	10,926		25	437	437	6,883	16
17	Backflow for Sprinkler		1993	2,909		25	116	116	1,761	17
18	Landscape/Fencing		1987	25,279		25	1,011	1,011	20,979	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 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 &amp; ID Number Rosewood Care Center Swansea

# 0032680

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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			2,607		38
39	Heat Pumps	2003	3,746		10	375	375	1,842		39
40	Roof Work	2004	21,620		40	540	540	2,162		40
41	Storage Building	2004	13,980		25	559	559	2,050		41
42	Parking Lot Seal & Stripe	2004	3,993		2			3,993		42
43	Telephone Power Pole	2005	10,875		10	1,088	1,088	3,172		43
44	Fire Alarm System	2005	9,668		10	967	967	2,659		44
45	Satellite System	2006	9,002		10	900	900	2,025		45
46	Heat Pumps	2007	37,285		10	3,729	3,729	4,485		46
47	Evaporative Cooling Tower	2007	48,252		10	4,825	4,825	5,629		47
48	Water Heater	2007	3,545		10	295	295	295		48
49	Compressor Blower Motor	2007	2,938		10	269	269	269		49
50	Water Heater	2007	3,594		10	271	271	271		50
51										51
52										52
53										53
54										54
55										55
56	Leasehold Improvements - Facility:									56
57	Carpet/Tile/Painting - Nurse Call Station	1993	20,471		7			20,471		57
58	Painting/Wallpaper	1994	15,422		7			15,422		58
59	Painting/Wallpaper/Tile	1995	25,375		7			25,375		59
60	Shelving	1995	2,186		7			2,186		60
61	New Upholsterv	1995	513		7			513		61
62	Design Work	1995	128		7			128		62
63	Carpeting	1996	5,580		7			5,580		63
64	Painting/Tiling	1996	6,383		7			6,383		64
65	Painting	1997	3,025		7			3,025		65
66	Tile & Base 2 Rooms	1997	1,400		7			1,400		66
67	2 Oak Doors	1997	803		7			803		67
68	Carpet & Installation	1998	7,951		7			7,951		68
69	Shower Renovations	1998	16,869		7			16,869		69
70	TOTAL (lines 4 thru 69)		\$ 3,545,711	\$		\$ 117,280	\$ 117,280	\$ 2,916,242		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	<b>Totals from Page 12A, Carried Forward</b>	\$ 3,545,711	\$		\$ 117,280	\$ 117,280	\$ 2,916,242		1
2	Paint/Wallpaper/Tile Removal	1,833		7			1,833		2
3	Shower Room	18,424		7			18,424		3
4	Wallpaper	273		7			273		4
5	Painting	970		7			970		5
6	Wallpaper	5,103		7			5,103		6
7	Carpet/Installation	5,106		7			5,106		7
8	Phone System	8,703		7			8,703		8
9	Wallpaper	4,450		7			4,450		9
10	Drapery	31,964		7			31,964		10
11	Computer Cabling	2,392	142	7	142		2,392		11
12	Painting	18,240	1,402	7	1,402		18,240		12
13	Cabling	606	87	7	87		606		13
14	Carpet	1,150	164	7	164		917		14
15	Wallcovering	3,554	508	7	508		2,369		15
16	Drywall	6,594	942	7	942		3,533		16
17	Shelving	2,271	324	7	324		1,216		17
18	Tile	5,918	845	7	845		3,029		18
19	Floor Tile & Base	4,203	601	7	601		1,602		19
20	Parking Lot Striping and Sealing	3,993	570	7	570		1,521		20
21	Repair Water Damaged Rooms	6,141	878	7	878		2,266		21
22	Drapes	4,666	472	7	472		1,056		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 3,682,265	\$ 6,935		\$ 124,215	\$ 117,280	\$ 3,031,815		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	\$ 170,280	\$	\$ 17,974	\$ 17,974	5-10 Yrs	\$ 105,916	71
72	Current Year Purchases	971		194	194	5-10 Yrs	194	72
73	Fully Depreciated Assets	444,270					444,270	73
74								74
75	TOTALS	\$ 615,521	\$	\$ 18,168	\$ 18,168		\$ 550,380	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	Midwest Admin. Services	Various	Various	\$ 24,295	\$	\$ 5,624	\$ 5,624	4 Yrs	\$ 9,058	76
77	Senior Living Services	Various	Various	184		46	46	4 Yrs	90	77
78										78
79										79
80	TOTALS			\$ 24,479	\$	\$ 5,670	\$ 5,670		\$ 9,148	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)	\$ 4,448,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,935	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,053	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 141,118	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,591,343	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?  YES  NO  
If NO, see instructions.

	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	<b>TOTAL</b>			\$			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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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	<b>TOTAL</b>		\$	\$	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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		5		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	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-8	hrs	\$	16,183	\$	223,457				16,183	\$	223,457	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		4,537		140,786				4,537		140,786	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-8	hrs		20,561		405,188		7,380		20,561		412,568	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						281,532				281,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify): <u>Labs, X-Rays, Enterals</u>	39-8					61,029		20,475				81,504	12
13	Other (specify):													13
14	TOTAL			\$	41,281	\$	830,460	\$	309,387		41,281	\$	1,139,847	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

Page 17

Facility Name &amp; ID Number      Rosewood Care Center Swansea

#      0032680

Report Period Beginning:      7/1/07

Ending:

6/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      6/30/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (158,494)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000 )	1,979,443		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,509		6
7	Other Prepaid Expenses	2,467		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,825,925	\$	10
	<b>B. Long-Term Assets</b>			
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	242,660		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(221,679)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 20,981	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,846,906	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 252,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,232		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,667		31
32	Accrued Real Estate Taxes(Sch.IX-B)	115,520		32
33	Accrued Interest Payable	20,324		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,700		35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Administration Fees	1,510,862		36
37	Notes Payable - Related Party	404,558		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,525,629	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,525,629	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (678,723)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,846,906	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 969,914	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 969,914	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(314,737)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(1,333,900)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (1,648,637)	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (678,723)	<b>24</b> *

\* 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: 7/1/07

Ending:

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6/30/08

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,175,035	1
2	Discounts and Allowances for all Levels	(2,293,903)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,881,132	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,972,179	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,972,179	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,025	13
14	Non-Patient Meals	5,732	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,757	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,367	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	167	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 167	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,865,602	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	986,571	31
32	Health Care	3,228,602	32
33	General Administration	2,880,738	33
<b>B. Capital Expense</b>			
34	Ownership	1,655,512	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	363,036	35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,180,339	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(314,737)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (314,737)	43

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. 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: 7/1/07

Ending: 6/30/08

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	2,000	2,145	\$ 69,528	\$ 32.41	1
2	Assistant Director of Nursing	1,925	2,064	58,012	28.11	2
3	Registered Nurses	17,988	19,293	504,047	26.13	3
4	Licensed Practical Nurses	27,292	29,272	572,342	19.55	4
5	CNAs & Orderlies	74,263	79,652	818,008	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,369	5,758	94,610	16.43	8
9	Activity Director					9
10	Activity Assistants	5,314	5,700	54,428	9.55	10
11	Social Service Workers	3,754	4,027	52,371	13.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,288	22,832	209,109	9.16	15
16	Dishwashers					16
17	Maintenance Workers	2,132	2,286	30,255	13.23	17
18	Housekeepers	15,850	17,001	146,186	8.60	18
19	Laundry	5,273	5,655	43,179	7.64	19
20	Administrator	1,950	2,093	79,964	38.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,244	10,988	160,111	14.57	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	7,697	8,255	97,831	11.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,339	217,021	\$ 2,989,981 *	\$ 13.78	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	Contract	\$ 7,906	1, 3	35
36	Medical Director	Contract	12,094	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	230	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	2,550	11, 3	44
45	Social Service Consultant	Contract	2,550	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,330		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	42	\$ 1,827	10-3	50
51	Licensed Practical Nurses	1,569	47,043	10-3	51
52	Certified Nurse Assistants/Aides	22	410	10-3	52
53	TOTAL (lines 50 - 52)	1,633	\$ 49,280		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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Schedule Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political 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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,498 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,732
- (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 \$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, INC.  
IDPH ID #0032680  
ATTACHMENT TO SCHEDULE XIX, Section C  
6/30/2008

**PROFESSIONAL SERVICES:**

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
Becker Paulson Hoerner & Thompson	Legal	\$12,415
C.J. Schlosser & Co.	Accountant/Consultant	2,450
Centers for MCR & MCD	CMP	6,000
Clerk of the Circuit Court	Arbitration Fee	500
Daniel Maher	Legal	4,786
Larson Allen	Accountant/Consultant	4,274
MPRO	Peer Review	1,035
Nelson Brothers		50
Old Republic Surety Group	Surety Bond	100
Sandberg, Phoenix & von Gontard	Legal	7,468
SJM & Co.	Consultant	2,291
Summer, Compton, Wells & Hamburg	Legal	1,775
Theresa Counts Burke	Legal	4,228
<b>Total</b>		<u><u>\$47,372</u></u>

ROSEWOOD CARE CENTER OF SWANSEA  
IDPH ID #0032680  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2008

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 8,131</u>
	<u>\$ 8,131</u>

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

ROSEWOOD CARE CENTER OF SWANSEA  
IDPH ID #0032680  
ATTACHMENT TO SCHEDULE VII, SECTION A  
6/30/2008

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTOM	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.
MIDWEST ADMINISTRATIVE SERVICES, INC.	ADMINISTRATIVE CO.
SWANSEA REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY
SENIOR LIVING SERVICES, INC.	BLDG SERVICES CO.