

Facility Name & ID Number Rosewood Care Center Swansea

0032680 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			11,325	11,325	8
9	SNF/PED					9
10	ICF	3,273	19,791		23,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,273	19,791	11,325	34,389	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.51%

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 11,325

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Rosewood Care Center Swansea # 0032680 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	210,239	20,267	12,392	242,898		242,898	(1,167)	241,731		1
2	Food Purchase		172,198		172,198		172,198	(10,900)	161,298		2
3	Housekeeping	168,635	31,423		200,058		200,058		200,058		3
4	Laundry	38,401	17,774		56,175		56,175		56,175		4
5	Heat and Other Utilities			152,567	152,567		152,567	199	152,766		5
6	Maintenance	31,392	8,400	305,867	345,659		345,659	7,158	352,817		6
7	Other (specify):* Garbage Collection			11,935	11,935		11,935		11,935		7
8	TOTAL General Services	448,667	250,062	482,761	1,181,490		1,181,490	(4,710)	1,176,780		8
	B. Health Care and Programs										
9	Medical Director			5,688	5,688		5,688		5,688		9
10	Nursing and Medical Records	2,146,076	174,967	28,238	2,349,281		2,349,281		2,349,281		10
10a	Therapy	105,282	16,757	805,541	927,580		927,580		927,580		10a
11	Activities	52,945	4,551	2,400	59,896		59,896		59,896		11
12	Social Services	57,922	13	2,400	60,335		60,335		60,335		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,362,225	196,288	844,267	3,402,780		3,402,780		3,402,780		16
	C. General Administration										
17	Administrative	241,413		502,500	743,913		743,913	(342,808)	401,105		17
18	Directors Fees										18
19	Professional Services			92,447	92,447	(3,041)	89,406	(47,762)	41,644		19
20	Dues, Fees, Subscriptions & Promotions			19,382	19,382	1,990	21,372	(9,864)	11,508		20
21	Clerical & General Office Expenses	153,277	60,442	299,286	513,005		513,005	(108,068)	404,937		21
22	Employee Benefits & Payroll Taxes			449,475	449,475		449,475	20,142	469,617		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,233	3,233	(1,990)	1,243	3,335	4,578		24
25	Other Admin. Staff Transportation			6,916	6,916		6,916	(2,175)	4,741		25
26	Insurance-Prop.Liab.Malpractice			68,286	68,286		68,286	5,792	74,078		26
27	Other (specify):*										27
28	TOTAL General Administration	394,690	60,442	1,441,525	1,896,657	(3,041)	1,893,616	(481,408)	1,412,208		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,205,582	506,792	2,768,553	6,480,927	(3,041)	6,477,886	(486,118)	5,991,768		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:

7/1/09

Ending:

6/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,314	7,314		7,314	132,385	139,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							735,698	735,698			32
33	Real Estate Taxes			71,113	71,113	3,041	74,154		74,154			33
34	Rent-Facility & Grounds			1,244,115	1,244,115		1,244,115	(1,225,022)	19,093			34
35	Rent-Equipment & Vehicles			39,783	39,783		39,783		39,783			35
36	Other (specify):*											36
37	TOTAL Ownership			1,362,325	1,362,325	3,041	1,365,366	(356,939)	1,008,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		369,928	72,055	441,983		441,983		441,983			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		369,928	137,755	507,683		507,683		507,683			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,205,582	876,720	4,268,633	8,350,935		8,350,935	(843,057)	7,507,878			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

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	(9,253)	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	(3,083)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,156)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(491)	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	(13,909)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,411)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,232)	20		28
29	Other-Attach Schedule	(85,255)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,790)		\$	30

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)	(723,267)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (723,267)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (843,057)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Swansea

ID# 0032680

Report Period Beginning: 7/1/09

Ending: 6/30/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Eliminate Marketing Salary	\$ (66,572)	21	1
2	Eliminate Marketing Mileage	(5,718)	25	2
3	Eliminate Lobbying & PAC Dues	(2,226)	20	3
4	Eliminate Out of Period IDPH License Fees	(995)	20	4
5	Offset Insurance Proceeds	(9,744)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(85,255)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Swansea# 0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	(1,167)	0	0	0	0	0	0	0	0	(1,167)	1
2	Food Purchase	(10,900)	0	0	0	0	0	0	0	0	0	0	(10,900)	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	199	0	0	0	0	0	0	0	0	199	5
6	Maintenance	(9,744)	7,254	9,648	0	0	0	0	0	0	0	0	7,158	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,644)	7,254	8,680	0	(4,710)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(342,808)	0	0	0	0	0	0	0	0	(342,808)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,909)	0	(33,853)	0	0	0	0	0	0	0	0	(47,762)	19
20	Fees, Subscriptions & Promotions	(9,864)	0	0	0	0	0	0	0	0	0	0	(9,864)	20
21	Clerical & General Office Expenses	(66,572)	0	(41,496)	0	0	0	0	0	0	0	0	(108,068)	21
22	Employee Benefits & Payroll Taxes	0	0	20,142	0	0	0	0	0	0	0	0	20,142	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,335	0	0	0	0	0	0	0	0	3,335	24
25	Other Admin. Staff Transportation	(5,718)	0	3,543	0	0	0	0	0	0	0	0	(2,175)	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,792	0	0	0	0	0	0	0	0	5,792	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(96,063)	0	(385,345)	0	(481,408)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(116,707)	7,254	(376,665)	0	(486,118)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Swansea# 0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	116,985	15,400	0	0	0	0	0	0	0	0	132,385	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,083)	738,781	0	0	0	0	0	0	0	0	0	735,698	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,244,115)	19,093	0	0	0	0	0	0	0	0	(1,225,022)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,083)	(388,349)	34,493	0	(356,939)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(119,790)	(381,095)	(342,172)	0	0	0	0	0	0	0	0	(843,057)	45

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
Rosewood Care Center Holding Co.	100	Section Not Applicable		See Attached		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	Swansea Real Estate, Inc.		\$ 116,985	\$ 116,985	1
2	V	32 Interest		Swansea Real Estate, Inc.		738,781	738,781	2
3	V	34 Rent	1,244,115	Swansea Real Estate, Inc.			(1,244,115)	3
4	V	6 Maintenance		Swansea Real Estate, Inc.		7,254	7,254	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,244,115			\$ 863,020	\$ * (381,095)	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	1 See Schedule VIII	\$ 4,800	HSM Management Services, Inc.		\$ 3,633	\$ (1,167)
16	V	5 See Schedule VIII		HSM Management Services, Inc.		199	199
17	V	6 See Schedule VIII		HSM Management Services, Inc.		9,648	9,648
18	V	17 See Schedule VIII	415,500	HSM Management Services, Inc.		72,692	(342,808)
19	V	19 See Schedule VIII	60,000	HSM Management Services, Inc.		26,147	(33,853)
20	V	6 Maintenance	71,466	HSM Management Services, Inc.		71,466	
21	V	21 See Schedule VIII	214,800	HSM Management Services, Inc.		173,304	(41,496)
22	V	22 See Schedule VIII		HSM Management Services, Inc.		20,142	20,142
23	V	24 See Schedule VIII		HSM Management Services, Inc.		3,335	3,335
24	V	25 See Schedule VIII		HSM Management Services, Inc.		3,543	3,543
25	V	26 See Schedule VIII		HSM Management Services, Inc.		5,792	5,792
26	V	30 See Schedule VIII		HSM Management Services, Inc.		15,400	15,400
27	V	34 See Schedule VIII		HSM Management Services, Inc.		19,093	19,093
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 766,566			\$ 424,394	\$ * (342,172)

* 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: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Administrative	0.00	24,159	4	7.08	Salary	\$ 1,841	17-8	1
2	Darrell Hoefling	Vice-President	Administrative	0.00	24,159	4	7.08	Salary	1,841	17-8	2
3											3
4											4
5	Larry Vander Maten	President	Administrative	0.00	0			Bonus	160,000	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,682		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:

7/1/09

Ending: 6/30/10

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	Dietary	Total Cost	18	\$ 51,303	\$ 51,303	7,226,928	\$ 3,633	1
2	5	Utilities	Total Cost	18	2,817		7,226,928	199	2
3	6	Maintenance	Total Cost	18	136,252		7,226,928	9,648	3
4	17	Salaries - Officers	Total Cost	18	52,143	52,143	7,226,928	3,692	4
5	19	Professional Services	Total Cost	18	367,489		7,226,928	26,022	5
6	21	Salaries - Other	Total Cost	18	2,017,832	2,017,832	7,226,928	142,885	6
7	21	Clerical & Office Supplies	Total Cost	18	426,339		7,226,928	30,190	7
8	22	Payroll Taxes & Emp. Benefits	Total Cost	18	284,443		7,226,928	20,142	8
9	24	Travel & Seminar	Total Cost	18	42,757		7,226,928	3,028	9
10	25	Other Admin Staff Transp	Total Cost	18	50,030		7,226,928	3,543	10
11	26	Insurance	Total Cost	18	24,472		7,226,928	1,733	11
12	30	Depreciation	Total Cost	18	198,269		7,226,928	14,040	12
13	34	Building Rent	Total Cost	18	269,633		7,226,928	19,093	13
14	17	Direct - Admin	Direct Cost	1	81,962	81,962		0	14
15	17	Administrative - Other	Direct Cost	1	69,000		1	69,000	15
16	19	Professional Services	Direct Cost	1	125		1	125	16
17	26	Insurance	Direct Cost	1	4,059		1	4,059	17
18	21	Office Supplies	Direct Cost	1	229		1	229	18
19	24	Travel & Seminar	Direct Cost	1	307		1	307	19
20	30	Direct - Depreciation	Direct Cost	1	1,360		1	1,360	20
21	30	Direct - Depreciation	Direct Cost	17	20,220			0	21
22									22
23									23
24									24
25	TOTALS				\$ 4,101,041	\$ 2,203,240		\$ 352,928	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Loan Refinancing	\$85,143.00	10/26/99	\$ 10,237,500	\$ 8,669,248	11/2009	8.8900	\$ 728,869	1							
2	Amortization of Loan Costs										9,971	2							
3	Less: Interst Income Offset										(3,083)	3							
4	Less: RE Co. Int. Income										(59)	4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$85,143.00		\$ 10,237,500	\$ 8,669,248			\$ 735,698	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 10,237,500	\$ 8,669,248			\$ 735,698	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.)

2009 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 2009 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 2009.

	(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>Wandering Woods</u>	\$ <u>72,259.18</u>	\$ <u>72,259.18</u>
2.	<u> </u>	<u>LOT/SEC-3 BK 52855-554 & 3023-25</u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>72,259.18</u></u>	\$ <u><u>72,259.18</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	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	#VALUE!		\$ 126,031	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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	\$ 55,752	\$ 55,752	\$ 2,046,770	4
5				1988	253,539		25	10,142	10,142	219,739	5
6				1990	222,972		20-25	8,582	8,582	178,290	6
7				1991	6,679		25	267	267	5,007	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	547	12
13		Landscaping		1989	1,904		25	76	76	1,635	13
14		Road		1990	431,970		25	17,279	17,279	345,578	14
15		Parking Lot Expansion		1989	27,592		15			27,592	15
16		Lawn Sprinkler System		1992	10,926		25	437	437	7,757	16
17		Backflow for Sprinkley		1993	2,909		10	116	116	1,994	17
18		Landscaping/Fencing		1987	25,279		25	1,011	1,011	23,001	18
19		Sinks		1987	4,156		10			4,156	19
20		Walk-In Cooler		1987	5,515		10			5,515	20
21		Exhaust Hood		1987	6,498		10			6,498	21
22		Hand Sinks		1987	181		10			181	22
23		Paging Systems		1987	632		10			632	23
24		Carpet		1987	39,910		10			39,910	24
25		Hospital Track/Curtain		1987	8,075		10			8,075	25
26		Signs		1987	2,916		10			2,916	26
27		Telephone Equipment		1987	3,180		10			3,180	27
28		Outside Sign		1987	4,504		10			4,504	28
29		Water Heater		1988	3,650		10			3,650	29
30		Walk-In Freezer		1988	3,936		15			3,936	30
31		Nurse Call System		1989	670		15			670	31
32		Sign		1989	2,000		10			2,000	32
33		Exhaust Fan		1989	530		10			530	33
34		Water Treatment System		1989	5,905		10			5,905	34
35		Door Guard		1989	5,509		10			5,509	35
36		Corner Guard		1990	1,446		10			1,446	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10**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	<u>Carpeting</u>	1990	\$ 2,215	\$	10	\$	\$	\$ 2,215	37
38	<u>Hot Water Storage Tank</u>	1996	2,607		10			2,607	38
39	<u>Heat Pumps</u>	2003	3,746		10	375	375	2,591	39
40	<u>Roof Work</u>	2004	21,620		40	541	541	3,243	40
41	<u>Storage Building</u>	2004	13,980		25	559	559	3,169	41
42	<u>Parking Lot Seal & Stripe</u>	2004	3,993		2			3,993	42
43	<u>Telephone Power Pole</u>	2005	10,875		10	1,088	1,088	5,347	43
44	<u>Fire Alarm System</u>	2005	9,668		10	967	967	4,592	44
45	<u>Satellite System</u>	2006	9,002		10	900	900	3,826	45
46	<u>Heat Pumps</u>	2007	37,285		10	3,729	3,729	11,942	46
47	<u>Evaporative Cooling Tower</u>	2007	48,252		10	4,825	4,825	15,280	47
48	<u>Water Heater</u>	2007	3,545		10	355	355	1,004	48
49	<u>Compressor Blower Motor</u>	2007	2,938		10	294	294	857	49
50	<u>Water Heater</u>	2007	3,594		10	360	360	989	50
51	<u>Electrical Wiring</u>	2009	3,153		10	315	315	447	51
52	<u>Painting Exterior Of Building</u>	2010	8,792		40	18	18	18	52
53	<u>Heat Pumps</u>	2009	6,327		10	422	422	422	53
54	<u>Exterior Doors</u>	2009	9,014		10	601	601	601	54
55	<u>Wall Cabinets</u>	2009	1,009		10	67	67	67	55
56	<u>Sprinkler Pipe</u>	2010	14,909		10	373	373	373	56
57	<u>Water Heater</u>	2010	4,040		10	67	67	67	57
58									58
59									59
60									60
61									61
62	<u>Leasehold Improvements - Facility:</u>								62
63	<u>Carbet/Tile/Painting - Nurse Call Station</u>	1993	20,471		7			20,471	63
64	<u>Painting/Wallpaper</u>	1994	15,422		7			15,422	64
65	<u>Painting/Wallpaper/Tile</u>	1995	25,375		7			25,375	65
66	<u>Shelving</u>	1995	2,186		7			2,186	66
67	<u>New Upholstery</u>	1995	513		7			513	67
68	<u>Design Work</u>	1995	128		7			128	68
69	<u>Carpeting</u>	1996	5,580		7			5,580	69
70	TOTAL (lines 4 thru 69)		\$ 3,556,524	\$		\$ 109,541	\$ 109,541	\$ 3,097,159	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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		\$ 3,556,524	\$		\$ 109,541	\$ 109,541	\$ 3,097,159	1
2	Painting/Tiling	1996	6,383		7			6,383	2
3	Painting	1997	3,025		7			3,025	3
4	Tile & Base 2 Rooms	1997	1,400		7			1,400	4
5	2 Oak Doors	1997	803		7			803	5
6	Carpet & Installation	1998	7,951		7			7,951	6
7	Shower Renovations	1998	16,869		7			16,869	7
8	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	8
9	Shower Room	1998	18,424		7			18,424	9
10	Wallpaper	1999	273		7			273	10
11	Painting	1998	970		7			970	11
12	Wallpaper	1998	5,103		7			5,103	12
13	Carpet/Installation	1998	5,106		7			5,106	13
14	Phone System	1998	8,703		7			8,703	14
15	Wallpaper	1998	4,450		7			4,450	15
16	Drapery	2000	31,964		7			31,964	16
17	Computer Cabling	2000	2,392		7			2,392	17
18	Painting	2001	18,240		7			18,240	18
19	Cabling	2001	606		7			606	19
20	Carpet	2002	1,150	68	7	68		1,150	20
21	Wallcovering	2004	3,554	508	7	508		3,385	21
22	Drywall	2004	6,594	943	7	943		5,417	22
23	Shelving	2004	2,271	324	7	324		1,865	23
24	Tile & Base 2 Rooms	2004	5,918	845	7	845		4,720	24
25	Floor Tile & Base	2005	4,203	600	7	600		2,802	25
26	Parking Lot Striping & Sealing	2005	3,993	570	7	570		2,662	26
27	Repair Water Damaged Rooms	2005	6,141	877	7	877		4,021	27
28	Drapes	2006	4,666	667	7	667		2,389	28
29	Carpet	2009	13,379	1,912	7	1,912		2,389	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,742,888	\$ 7,314		\$ 116,855	\$ 109,541	\$ 3,262,454	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:

7/1/09

Ending:

6/30/10

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	\$ 105,058	\$	\$ 14,730	\$ 14,730	5-10 Yrs.	\$ 69,867	71
72	Current Year Purchases	8,055		1,326	1,326	5-10 Yrs.	1,326	72
73	Fully Depreciated Assets	507,321					507,321	73
74								74
75	TOTALS	\$ 620,434	\$	\$ 16,056	\$ 16,056		\$ 578,514	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	\$ 32,373	\$	\$ 6,788	\$ 6,788	4	\$ 16,766	76
77										77
78										78
79										79
80	TOTALS			\$ 32,373	\$	\$ 6,788	\$ 6,788		\$ 16,766	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)	\$ 4,521,726	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,314	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,699	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 132,385	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,857,734	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

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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a, 3	hrs	\$	12,017	\$	248,752	\$	12,017	\$	248,752	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		4,532		93,813		4,532		93,813	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a,3	hrs		22,366		462,976		22,366		479,733	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39, 2	# of prescripts					359,858			359,858	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, 2 & 39, 3					72,055	10,070			82,125	12
13	Other (specify):											13
14	TOTAL			\$	38,915	\$	877,596	\$	38,915	\$	1,264,281	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

Facility Name & ID Number Rosewood Care Center Swansea

0032680

Report Period Beginning: 7/1/09

Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (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	\$ 2,272	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>179,000</u>)	930,489		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,381		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Receivables</u>	44,805		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 986,381	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	256,039		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(234,969)		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): <u>Deposits</u>	2,467		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,537	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,009,918	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 480,089	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,635		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,224		31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,111		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,700		35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	247,779		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,123,538	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,123,538	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (113,620)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,009,918	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (243,172)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (243,172)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	129,552	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 129,552	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)	\$ (113,620)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center Swansea**# **0032680**Report Period Beginning: **7/1/09**

Ending:

6/30/10

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	\$ 8,915,418	1
2	Discounts and Allowances for all Levels	(2,288,403)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,627,015	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,825,055	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,825,055	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	9,253	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)	\$ 12,553	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,083	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,083	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	9,744	27
28	Vendor Discounts	1,156	28
28a	Miscellaneous	1,881	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,781	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,480,487	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,181,490	31
32	Health Care	3,402,780	32
33	General Administration	1,896,657	33
B. Capital Expense			
34	Ownership	1,362,325	34
C. Ancillary Expense			
35	Special Cost Centers	441,983	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)*	\$ 8,350,935	40
41	Income before Income Taxes (line 30 minus line 40)**	129,552	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 129,552	43

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

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

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

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

Facility Name & ID Number **Rosewood Care Center Swansea**

0032680

Report Period Beginning:

7/1/09

Ending:

6/30/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,948	2,081	\$ 71,604	\$ 34.41	1
2	Assistant Director of Nursing	1,925	2,056	63,571	30.92	2
3	Registered Nurses	19,344	20,662	555,469	26.88	3
4	Licensed Practical Nurses	28,068	29,981	584,976	19.51	4
5	CNAs & Orderlies	69,715	74,466	767,216	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,761	6,154	105,282	17.11	8
9	Activity Director					9
10	Activity Assistants	5,297	5,658	52,945	9.36	10
11	Social Service Workers	4,032	4,307	57,922	13.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,139	22,580	210,239	9.31	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,224	31,392	14.12	17
18	Housekeepers	17,109	18,275	168,635	9.23	18
19	Laundry	4,376	4,674	38,401	8.22	19
20	Administrator	1,927	2,058	81,413	39.56	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	160,000	76.92	22
23	Office Manager					23
24	Clerical	9,896	10,570	153,277	14.50	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	5,864	6,263	103,240	16.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,563	214,089	\$ 3,205,582 *	\$ 14.97	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	\$ 7,592	1, 3	35
36	Medical Director	Contract	5,688	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,148	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,400	11, 3	44
45	Social Service Consultant	Contract	2,400	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,228		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	234	\$ 9,429	10-3	50
51	Licensed Practical Nurses	415	13,501	10-3	51
52	Certified Nurse Assistants/Aides	10	160	10-3	52
53	TOTAL (lines 50 - 52)	659	\$ 23,090		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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Swansea# 0032680Report Period Beginning: 7/1/09Ending: 6/30/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$4,388
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,401 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,253
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF SWANSEA
IDPH ID # 0032680
Attachment to Schedule VII, Section A
6/30/2010

Name	City	Type of Business
Other Related Business Entities:		
HSM Management Services, Inc.	St. Louis, Mo	Management Co.
Midwest Administrative Services, Inc.	St. Louis, Mo	Administrative Co.
Swansea Real Estate, Inc.	St. Louis, Mo	Real Estate Lsg.
Rosewood Home Health	St. Louis, Mo	Home Health Co.