

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	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			2,919	2,919	8
9	SNF/PED					9
10	ICF	22,313	1,148		23,461	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,313	1,148	2,919	26,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.70%

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 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 2,919

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTE # 0041780 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	157,544	20,107	7,855	185,506		185,506	0	185,506		1
2	Food Purchase		129,628		129,628	0	129,628	(644)	128,984		2
3	Housekeeping	105,620	40,971	0	146,591		146,591	0	146,591		3
4	Laundry	40,155	12,559	0	52,714	0	52,714	0	52,714		4
5	Heat and Other Utilities			87,195	87,195		87,195	19	87,214		5
6	Maintenance	36,122	26,020	28,866	91,008		91,008	3,192	94,200		6
7	Other (specify):*			9,964	9,964		9,964	9	9,973		7
8	TOTAL General Services	339,441	229,285	133,880	702,606	0	702,606	2,576	705,182		8
	B. Health Care and Programs										
9	Medical Director	0		8,500	8,500		8,500	0	8,500		9
10	Nursing and Medical Records	1,175,857	83,604	4,221	1,263,682		1,263,682	23,560	1,287,242		10
10a	Therapy	52,891	2,771	97,717	153,379		153,379	(9,876)	143,503		10a
11	Activities	52,350	12,561	445	65,356		65,356	0	65,356		11
12	Social Services	5,080		3,748	8,828		8,828	0	8,828		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			1,300	1,300		1,300	0	1,300		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,286,178	98,936	115,931	1,501,045	0	1,501,045	13,684	1,514,729		16
	C. General Administration										
17	Administrative	70,342		0	70,342		70,342	53,165	123,507		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			208,284	208,284		208,284	(146,621)	61,663		19
20	Dues, Fees, Subscriptions & Promotions			40,538	40,538		40,538	(25,408)	15,130		20
21	Clerical & General Office Expenses	194,443	20,117	161,331	375,891		375,891	(100,207)	275,684		21
22	Employee Benefits & Payroll Taxes			317,228	317,228	0	317,228	0	317,228		22
23	Inservice Training & Education			5,130	5,130		5,130	998	6,128		23
24	Travel and Seminar			806	806		806	563	1,369		24
25	Other Admin. Staff Transportation			8,206	8,206		8,206	1,552	9,758		25
26	Insurance-Prop.Liab.Malpractice			61,315	61,315		61,315	752	62,067		26
27	Other (specify):*			0	0		0	29,085	29,085		27
28	TOTAL General Administration	264,785	20,117	802,838	1,087,740	0	1,087,740	(186,121)	901,619		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,890,404	348,338	1,052,649	3,291,391	0	3,291,391	(169,861)	3,121,530		29

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

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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,511
	REPAIRS & MAINTENANCE	1,344
		0
		7,855
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,707
	ELECTRICITY	33,285
	WATER	10,789
	CABLE TV - LOBBY	10,414
		0
		87,195
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,040
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,183
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,511
	FIRE SERVICE	6,132
		0
		0
		0
		0
		28,866
7	OTHER	
	SCAVENGER	9,964
	SECURITY SERVICE	0
		0
		0
		9,964
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,500
		8,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	581
	PHARMACY CONSULTANT XVIII B 39-2	1,140
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	2,500
	RN CONSULTANT XVIII B 38-2	0
		0
		4,221
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	5,760
	SPEECH THERAPY SERVICES	2,431
	OCCUPATIONAL THERAPY SERVICES	5,153
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	73,573
		97,717
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	445
		0
		445
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,748
		0
		3,748
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,300
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,209
	ADMINISTRATIVE CONSULTANTS XIX C	132,000
	PROFESSIONAL FEES XIX C	52,075
		0
		208,284
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	26,644
	EMPLOYEE WANT ADS XIX F	11,513
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	213
	LICENSES & PERMITS XIX F	1,935
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	50
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	183
	PATIENT BACKGROUND CHECKS XIX F	0
		40,538
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,133
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	70,608
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,980
	MESSENGER SERVICE	3,610
		0
		161,331

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	143,660
	UNEMPLOYMENT COMPENSATION XIX D	84,134
	WORKERS COMPENSATION INSURANC XIX D	73,060
	HOSPITALIZATION INSURANCE XIX D	14,948
	EMPLOYEE BENEFITS - OTHER XIX D	980
	EMPLOYEE PHYSICAL EXAMS XIX D	446
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		317,228
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,130
		5,130
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	806
		806
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,206
		8,206
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	61,315
		61,315
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,052,649

ROSE GARDEN CONVALESCENT CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	129,628	PATIENT MEALS	79140
LESS SALES TAX	(644)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	128,984	TOTAL MEALS/YEAR	79140
TOTAL PATIENT CENSUS	26,380	NET FOOD	128984
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	79140

TOTAL PATIENT MEALS	79140	COST PER MEAL	1.63
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

ROSE GARDEN CONVALESCENT CENTER

#0041780

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,971	7,971		7,971	98,611	106,582			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			83,271	83,271		83,271	314,039	397,310			32
33	Real Estate Taxes			68,777	68,777		68,777	2,376	71,153			33
34	Rent-Facility & Grounds			315,343	315,343		315,343	(315,343)	0			34
35	Rent-Equipment & Vehicles			87,723	87,723		87,723	(36,000)	51,723			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			563,085	563,085	0	563,085	63,683	626,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		105,887	115,981	221,868		221,868	(14,342)	207,526			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			60,225	60,225		60,225	0	60,225			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	105,887	176,206	282,093	0	282,093	(14,342)	267,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,890,404	454,225	1,791,940	4,136,569	0	4,136,569	(120,520)	4,016,049			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(1,022)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(644)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(70,608)	21		18
19	Entertainment	0	20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(4,389)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(26,644)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(55)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (103,412)		\$ 0	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)	(17,108)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (17,108)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (120,520)		37

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

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

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

ID# 0041780

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NON ALLOWABLE SEMINAR EXPENSE	\$ (55)	23	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				48
49	Total	(55)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(644)	0	0	0	0	0	0	0	0	0	0	(644)	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	19	0	0	0	0	0	0	0	0	19	5
6	Maintenance	0	0	3,192	0	0	0	0	0	0	0	0	3,192	6
7	Other (specify):*	0	0	9	0	0	0	0	0	0	0	0	9	7
8	TOTAL General Services	(644)	0	3,220	0	2,576	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	23,560	0	0	0	0	0	0	0	0	23,560	10
10a	Therapy	0	(11,469)	1,593	0	0	0	0	0	0	0	0	(9,876)	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	(11,469)	25,153	0	13,684	16							
	C. General Administration													
17	Administrative	0	0	53,165	0	0	0	0	0	0	0	0	53,165	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,389)	0	(142,232)	0	0	0	0	0	0	0	0	(146,621)	19
20	Fees, Subscriptions & Promotions	(26,694)	0	1,286	0	0	0	0	0	0	0	0	(25,408)	20
21	Clerical & General Office Expenses	(70,608)	0	(29,599)	0	0	0	0	0	0	0	0	(100,207)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(55)	0	1,053	0	0	0	0	0	0	0	0	998	23
24	Travel and Seminar	0	0	563	0	0	0	0	0	0	0	0	563	24
25	Other Admin. Staff Transportation	0	0	1,552	0	0	0	0	0	0	0	0	1,552	25
26	Insurance-Prop.Liab.Malpractice	0	0	752	0	0	0	0	0	0	0	0	752	26
27	Other (specify):*	0	0	29,085	0	0	0	0	0	0	0	0	29,085	27
28	TOTAL General Administration	(101,746)	0	(84,375)	0	(186,121)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102,390)	(11,469)	(56,002)	0	(169,861)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,022)	93,730	5,903	0	0	0	0	0	0	0	0	98,611	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	296,881	17,158	0	0	0	0	0	0	0	0	314,039	32
33	Real Estate Taxes	0	0	2,376	0	0	0	0	0	0	0	0	2,376	33
34	Rent-Facility & Grounds	0	(315,343)	0	0	0	0	0	0	0	0	0	(315,343)	34
35	Rent-Equipment & Vehicles	0	(40,407)	4,407	0	0	0	0	0	0	0	0	(36,000)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,022)	34,861	29,844	0	63,683	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	(14,342)	0	0	0	0	0	0	0	0	0	(14,342)	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	(14,342)	0	0	0	0	0	0	0	0	0	(14,342)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(103,412)	9,050	(26,158)	0	(120,520)	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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				ROSE GARDEN CARE CENTER LLC		REAL ESTATE
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					SKOKIE	

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	34 RENT	\$ 315,343	ROSE GARDEN CARE CENTER LLC	100.00%	\$	\$ (315,343)	1
2	V	30 SL DEPRECIATION		" "		88,640	88,640	2
3	V	32 INTEREST		" "		293,165	293,165	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V	10a THERAPY SERVICES	94,953	CAREPLUS REHABILITATIVE SERVICES		83,484	(11,469)	8
9	V	39 ANCILLARY THERAPY	118,742	" "		104,400	(14,342)	9
10	V	30 DEPRECIATION		" "		5,090	5,090	10
11	V	32 INTEREST		" "		3,716	3,716	11
12	V	35 EQUIPMENT RENT	40,407	" "			(40,407)	12
13	V							13
14	Total		\$ 569,445			\$ 578,495	\$ * 9,050	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 ADMIN CONSLT/DATA PROCESSING	\$ 144,000	CAREPLUS MGMT INC		\$	\$ (144,000)
16	V	21 HOME OFFICE/CLERICAL FEES	66,000	"			(66,000)
17	V	27 W/C INSURANCE	6,140	"			(6,140)
18	V			"			
19	V	5 UTILITIES		"		19	19
20	V	6 MAINT & REPAIRS		"		797	797
21	V	6 MAINTENANCE SALARIES		"		2,395	2,395
22	V	7 SECURITY		"		9	9
23	V	10 NURSING SALARIES		"		23,560	23,560
24	V	10a THERAPY SALARIES		"		1,593	1,593
25	V	17 ADMIN SALARIES		"		53,165	53,165
26	V	19 PROFESSIONAL FEES		"		1,768	1,768
27	V	20 ADVERTISING		"		1,286	1,286
28	V	21 OFFICE EXPENSE		"		7,845	7,845
29	V	21 OFFICE SALARIES		"		28,556	28,556
30	V	23 SEMINARS		"		1,053	1,053
31	V	24 TRAVEL		"		563	563
32	V	25 TRANSPORTATION		"		1,552	1,552
33	V	26 INSURANCE		"		752	752
34	V	27 EMPLOYEE BENEFITS		"		35,225	35,225
35	V	30 DEPRECIATION		"		5,903	5,903
36	V	33 REAL ESTATE TAX		"		2,376	2,376
37	V	32 INTEREST		"		17,158	17,158
38	V	35 EQUIPMENT RENT		"		4,407	4,407
39	Total		\$ 216,140			\$ 189,982	\$ * (26,158)

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENT # 0041780 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	JAKOB BAKST				SEE ATTACHED			SALARY	\$ 9,537	17-7	1
2	SHERWIN I. RAY				SCHEDULES			SALARY	9,537	17-7	2
3	JAMEE O'BRIEN				" "			SALARY	6,503	17-7	3
4	JOE ANN BREW				" "			SALARY	4,088	17-7	4
5	JANICE CLAFFORD				" "			SALARY	3,601	17-7	5
6	JOE ZIMMERMAN				" "			SALARY	4,792	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 38,058		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

Facility Name & ID Number **ROSE GARDEN CONVALESCENT CENTER**

0041780

Report Period Beginning:

01/01/2006

Ending: **2/31/2006**

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 CAREPLUS MGMT
 Street Address 8320 SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-1555
 Fax Number (847) 329-9555

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	5	UTILITIES	PATIENT DAYS	553,205	13	\$ 408	26,380	\$ 19	1
2	6	MAINT & REPAIRS	" "	553,205	13	16,722	26,380	797	2
3	6	MAINTENANCE SALARIES	" "	553,205	13	50,215	26,380	2,395	3
4	7	SECURITY	" "	553,205	13	194	26,380	9	4
5	10	NURSING SALARIES	" "	553,205	13	494,063	26,380	23,560	5
6	10a	THERAPY SALARIES	" "	553,205	13	33,400	26,380	1,593	6
7	17	ADMIN SALARIES	" "	553,205	13	1,114,897	26,380	53,165	7
8	19	PROFESSIONAL FEES	" "	553,205	13	37,085	26,380	1,768	8
9	20	ADVERTISING	" "	553,205	13	26,974	26,380	1,286	9
10	21	OFFICE EXPENSE	" "	553,205	13	164,515	26,380	7,845	10
11	21	OFFICE SALARIES	" "	553,205	13	598,842	26,380	28,556	11
12	23	SEMINARS	" "	553,205	13	22,090	26,380	1,053	12
13	24	TRAVEL	" "	553,205	13	11,815	26,380	563	13
14	25	TRANSPORTATION	" "	553,205	13	32,553	26,380	1,552	14
15	26	INSURANCE	" "	553,205	13	15,760	26,380	752	15
16	27	EMPLOYEE BENEFITS	" "	553,205	13	738,700	26,380	35,225	16
17	30	DEPRECIATION	" "	553,205	13	123,804	26,380	5,903	17
18	33	REAL ESTATE TAX	" "	553,205	13	49,822	26,380	2,376	18
19	32	INTEREST	" "	553,205	13	359,819	26,380	17,158	19
20	35	EQUIPMENT RENT	" "	553,205	13	92,424	26,380	4,407	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,984,102	\$ 2,291,417	\$ 189,982	25

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	RELATED PARTY:ROSE GARDEN CENTER LLC						\$	\$			\$	1
2	AMERICAN NATIONAL BANK	X		MORTGAGE	09/98						132,481	2
3	CIB	X		CAPITAL IMPROV LOAN				12,870			1,324	3
4	AMCORE BANK	X		MORTGAGE				2,880,700			159,360	4
5	RELATED PARTY	X									17,158	5
Working Capital												
6	SHAREHOLDER/PARTNER	X		WORKING CAPITAL				1,610,400			49,538	6
7	CARE PLUS MGMT	X		WORKING CAPITAL				730,480			33,733	7
8												8
9	TOTAL Facility Related						\$ 0	\$ 5,234,450			\$ 393,594	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)						\$ 0	\$ 5,234,450			\$ 393,594	15

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	66,000	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.)		\$	66,777	2
3. Under or (over) accrual (line 2 minus line 1).		\$	777	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	68,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	68,777	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	53,993	8	
	2002	58,259	9	
	2003	62,206	10	
	2004	64,334	11	
	2005	66,777	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSE GARDEN CONVALESCENT CENTER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>14-15-426-004</u>	<u>NURSING HOME</u>	\$ <u>66,777.04</u>	\$ <u>66,777.04</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>66,777.04</u>	\$ <u>66,777.04</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1 NO BASEMENT

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).

N/A

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>400,860</u>	<u>1998</u>	<u>\$ 126,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	400,860		\$ 126,500	3

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	110	1998		\$ 2,536,069	\$ 65,025	39	\$ 65,025		\$ 539,195	4
5				884,255	23,615	39	23,615		246,583	5
6										6
7	RELATED PARTY-TAG 18				765		765			7
8	RELATED PARTY-TAG 18 IMPRV				453		453			8
Improvement Type**										
9	CARE PLUS REHAB:									9
10	WATER HEATER		2004	10,051	257	39	257		996	10
11										11
12	SEWER LINE/FIRE RATED WALL		2005	16,205	589	27.5	589		858	12
13	TILE/CARPET		2005	2,583	94	27.5	94		138	13
14	SIDEWALKS		2006	3,700	124	27.5	124		124	14
15	SECURITY LOCKS/CAMERA SYSTEM		2006	11,010	184	27.5	184		184	15
16	GABLE WORK		2006	1,740	29	27.5	29		29	16
17	ROOFTOP AC & HEAT		2006	12,315	205	27.5	205		205	17
18	BATHROOM REMODEL		2006	2,950	49	27.5	49		49	18
19	ELECTRIC WORK		2006	2,575	43	27.5	43		43	19
20	THREE COMPARTMENT SINK & FAUCET		2006	2,000	33	27.5	33		33	20
21	TILE WORK IN KITCHEN		2006	6,862	115	27.5	115		115	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70	
			3,492,315		91,580		91,580	0	788,552

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 49,869	\$ 5,746	\$ 4,724	\$ (1,022)	10 yrs	\$ 25,019	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	864,995	4,685	4,685	0			74
75	TOTALS	\$ 914,864	\$ 10,431	\$ 9,409	\$ (1,022)		\$ 25,019	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 4,533,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,011	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,989	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,022)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 813,571	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 85,654 Description: SEE SCHEDULE ATTACHED

(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	CP MGMT ALLOC			2,069	19
20					20
21	TOTAL		\$	\$ 2,069	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 50,860	\$		\$ 50,860	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,214			12,214	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			52,907			52,907	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				93,969		93,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB, OTHER						11,918		11,918	13
14	TOTAL			\$		\$ 115,981	\$ 105,887		\$ 221,868	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.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 4,851	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,011,076		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,097		6
7	Other Prepaid Expenses	38,280		7
8	Accounts Receivable (owners or related parties)	48,116		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,132,420	\$ 0	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	61,940		15
16	Equipment, at Historical Cost	49,869		16
17	Accumulated Depreciation (book methods)	(42,752)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,057	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,201,477	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 720,582	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,758		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,324		31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,000		32
33	Accrued Interest Payable	338,711		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,253,375	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,558,847		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)	\$ 2,558,847	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,812,222	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,610,745)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,201,477	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (512,711)	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(96,156)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (608,867)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,001,878)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,001,878)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,610,745)	24 *

* This must agree with page 17, line 47.

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	\$ 3,102,998	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,102,998	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	31,693	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 31,693	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		13
14	Non-Patient Meals		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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,134,691	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	702,606	31
32	Health Care	1,501,045	32
33	General Administration	1,087,740	33
	B. Capital Expense		
34	Ownership	563,085	34
	C. Ancillary Expense		
35	Special Cost Centers	221,868	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,136,569	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,001,878)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,001,878)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,172	2,476	\$ 63,899	\$ 25.81	1
2	Assistant Director of Nursing	1,784	2,044	46,108	22.56	2
3	Registered Nurses	5,228	5,750	165,324	28.75	3
4	Licensed Practical Nurses	17,989	19,677	414,222	21.05	4
5	CNAs & Orderlies	43,616	47,910	486,304	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,592	4,895	52,891	10.81	8
9	Activity Director	2,030	2,143	28,447	13.27	9
10	Activity Assistants	1,380	1,507	23,903	15.86	10
11	Social Service Workers	200	280	5,080	18.14	11
12	Dietician					12
13	Food Service Supervisor	1,100	1,238	14,938	12.07	13
14	Head Cook	6,087	6,790	58,076	8.55	14
15	Cook Helpers/Assistants	9,214	10,220	84,530	8.27	15
16	Dishwashers					16
17	Maintenance Workers	2,608	2,730	36,122	13.23	17
18	Housekeepers	12,017	13,160	105,620	8.03	18
19	Laundry	5,026	5,456	40,155	7.36	19
20	Administrator	1,984	2,120	70,342	33.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,057	10,962	194,443	17.74	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,084	139,358	\$ 1,890,404 *	\$ 13.57	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	M	\$ 6,511	1-3	35
36	Medical Director	O	8,500	9-3	36
37	Medical Records Consultant	N	581	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,140	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	445	11-3	44
45	Social Service Consultant	E	3,748	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,725		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LORENE FOUST	ADMINISTRATOR		\$ 70,342	Workers' Compensation Insurance	\$ 73,060	IDPH License Fee	\$	
				Unemployment Compensation Insurance	84,134	Advertising: Employee Recruitment	11,513	
				FICA Taxes	143,660	Health Care Worker Background Check	183	
				Employee Health Insurance	14,948	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	50	
				EMPLOYEE BENEFITS - OTHER	980	MARKETING/ADV/PROMO	26,644	
				EMPLOYEE PHYSICAL EXAMS	446	LICENSES/DUES/SUBSCRIPTIONS	2,148	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,286	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(50)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(26,644)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,342	TOTAL (agree to Schedule V, line 22, col.8)	\$ 317,228	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,130	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								806
							MGMT CO ALLOC	563
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,369
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$			\$		
SEE SCHEDULE ATTACHED			208,284					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 208,284					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

0041780

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
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? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees