

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0032805

**Facility Name:** Rosewood Care Center Galesburg

**Address:** 1250 West Carl Sandburg Drive Galesburg 61401  
 Number City Zip Code

**County:** Knox

**Telephone Number:** (319) 344-5400 Fax # ( )

**HFS ID Number:** 431375391001

**Date of Initial License for Current Owners:** 12/9/1987

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Cindy A. Tefteller **Telephone Number:** (618) 465-7717

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2005 to 6/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) <u>Accountant's Compilation Report Attached</u>	(Date) _____
	(Print Name and Title) <u>Cindy A. Tefteller</u>	
	(Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>	
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	

**MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	<u>180</u>	Skilled (SNF)	<u>180</u>	<u>65,700</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,771</u>	<u>3,771</u>	8
9	SNF/PED					9
10	ICF	<u>23,454</u>	<u>9,315</u>		<u>32,769</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,454</u>	<u>9,315</u>	<u>3,771</u>	<u>36,540</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.62%

D. How many bed-hold days during this year were paid by the Department? 146 (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 12/1/1987

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

YES  Date 12/1/1987 NO

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

YES  NO  If YES, enter number of beds certified 32 and days of care provided 3,771

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

**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	
	<b>A. General Services</b>											
1	Dietary	201,901	21,038	7,168	230,107		230,107	583	230,690			1
2	Food Purchase		160,695		160,695		160,695	(5,818)	154,877			2
3	Housekeeping	150,280	25,032		175,312		175,312		175,312			3
4	Laundry	50,818	15,084		65,902		65,902		65,902			4
5	Heat and Other Utilities			137,347	137,347		137,347		137,347			5
6	Maintenance	23,955	4,109	83,827	111,891		111,891	40,959	152,850			6
7	Other (specify):* <b>Sanitation</b>			13,112	13,112		13,112		13,112			7
8	<b>TOTAL General Services</b>	<b>426,954</b>	<b>225,958</b>	<b>241,454</b>	<b>894,366</b>		<b>894,366</b>	<b>35,724</b>	<b>930,090</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,875	9,875		9,875		9,875			9
10	Nursing and Medical Records	1,747,493	167,444	97,002	2,011,939		2,011,939		2,011,939			10
10a	Therapy	72,474	1,567	252,133	326,174		326,174	33,267	359,441			10a
11	Activities	44,165	3,358	2,400	49,923		49,923		49,923			11
12	Social Services	51,379	9	2,400	53,788		53,788		53,788			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,915,511</b>	<b>172,378</b>	<b>363,810</b>	<b>2,451,699</b>		<b>2,451,699</b>	<b>33,267</b>	<b>2,484,966</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	16,773		185,625	202,398		202,398	(36,166)	166,232			17
18	Directors Fees											18
19	Professional Services			8,270	8,270		8,270	45,530	53,800			19
20	Dues, Fees, Subscriptions & Promotions			26,199	26,199		26,199	(5,490)	20,709			20
21	Clerical & General Office Expenses	143,346	25,492	15,104	183,942		183,942	143,848	327,790			21
22	Employee Benefits & Payroll Taxes			304,333	304,333		304,333	28,324	332,657			22
23	Inservice Training & Education											23
24	Travel and Seminar			766	766		766		766			24
25	Other Admin. Staff Transportation			4,159	4,159		4,159	14,637	18,796			25
26	Insurance-Prop.Liab.Malpractice			78,629	78,629		78,629	14,240	92,869			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>160,119</b>	<b>25,492</b>	<b>623,085</b>	<b>808,696</b>		<b>808,696</b>	<b>204,923</b>	<b>1,013,619</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,502,584</b>	<b>423,828</b>	<b>1,228,349</b>	<b>4,154,761</b>		<b>4,154,761</b>	<b>273,914</b>	<b>4,428,675</b>			<b>29</b>

\*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 Galesburg #0032805 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	<b>D. Ownership</b>											
30	Depreciation			5,079	5,079		5,079	216,748	221,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							578,972	578,972			32
33	Real Estate Taxes			144,094	144,094		144,094		144,094			33
34	Rent-Facility & Grounds			829,000	829,000		829,000	(817,889)	11,111			34
35	Rent-Equipment & Vehicles			13,563	13,563		13,563		13,563			35
36	Other (specify):* <b>Mortgage Insur.</b>											36
37	<b>TOTAL Ownership</b>			991,736	991,736		991,736	(22,169)	969,567			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,446	20,031	108,477		108,477		108,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		88,446	118,581	207,027		207,027		207,027			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,502,584	512,274	2,338,666	5,353,524		5,353,524	251,745	5,605,269			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

**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	(5,615)	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	(9,697)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(203)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,429)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,331)	20		28
29	Other-Attach Schedule Marketing Salary	(60,901)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (83,176)</b>		<b>\$</b>	<b>30</b>

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)	334,921	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 334,921</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 251,745</b>		<b>37</b>

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Galesburg

ID# 0032805

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (60,901)	21
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49	<b>Total</b>	(60,901)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	583	0	0	0	0	0	0	0	0	583	1
2	Food Purchase	(5,818)	0	0	0	0	0	0	0	0	0	0	(5,818)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	8,188	32,771	0	0	0	0	0	0	0	0	40,959	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,818)</b>	<b>8,188</b>	<b>33,354</b>	<b>0</b>	<b>35,724</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	33,267	0	0	0	0	0	0	0	0	0	33,267	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>33,267</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33,267</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(185,625)	149,459	0	0	0	0	0	0	0	0	(36,166)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	45,530	0	0	0	0	0	0	0	0	45,530	19
20	Fees, Subscriptions & Promotions	(6,760)	0	1,270	0	0	0	0	0	0	0	0	(5,490)	20
21	Clerical & General Office Expenses	(60,901)	0	204,749	0	0	0	0	0	0	0	0	143,848	21
22	Employee Benefits & Payroll Taxes	0	0	28,324	0	0	0	0	0	0	0	0	28,324	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	14,637	0	0	0	0	0	0	0	0	14,637	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	8,449	0	0	0	0	0	0	0	0	14,240	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(67,661)</b>	<b>(179,834)</b>	<b>452,418</b>	<b>0</b>	<b>204,923</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(73,479)</b>	<b>(138,379)</b>	<b>485,772</b>	<b>0</b>	<b>273,914</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	205,700	11,048	0	0	0	0	0	0	0	0	216,748	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,697)	588,669	0	0	0	0	0	0	0	0	0	578,972	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(829,000)	11,111	0	0	0	0	0	0	0	0	(817,889)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(9,697)</b>	<b>(34,631)</b>	<b>22,159</b>	<b>0</b>	<b>(22,169)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(83,176)</b>	<b>(173,010)</b>	<b>507,931</b>	<b>0</b>	<b>251,745</b>	<b>45</b>							

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 174,150	HSM Management	0.00%	\$	\$ (174,150)	1
2	V	17 Adminstrative Fee	11,475	Midwest Administrative Services	0.00%		(11,475)	2
3	V							3
4	V	10a Therapy	252,133	Rosewood Therapy Services, Inc.	0.00%	285,400	33,267	4
5	V							5
6	V	34 Rent	829,000	Galesburg Real Estate, Inc.	0.00%		(829,000)	6
7	V	30 Depreciation		Galesburg Real Estate, Inc.	0.00%	205,524	205,524	7
8	V	32 Interest		Galesburg Real Estate, Inc.	0.00%	588,669	588,669	8
9	V	26 Property Insurance		Galesburg Real Estate, Inc.	0.00%	5,791	5,791	9
10	V							10
11	V	6 Repairs & Maintenance	1,377	Senior Living Services	0.00%	9,565	8,188	11
12	V	30 Depreciation		Senior Living Services	0.00%	176	176	12
13	V							13
14	Total		\$ 1,268,135			\$ 1,095,125	\$ * (173,010)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg# 0032805Report Period Beginning: 7/1/2005Ending: 6/30/2006**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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	17	See Schedule VIII	\$	HSM Management Services, Inc.	0.00%	\$ 122,218	\$ 122,218		15	
16	V	21	See Schedule VIII		HSM Management Services, Inc.	0.00%	177,337	177,337		16	
17	V	22	See Schedule VIII		HSM Management Services, Inc.	0.00%	24,682	24,682		17	
18	V	25	See Schedule VIII		HSM Management Services, Inc.	0.00%	13,398	13,398		18	
19	V	30	See Schedule VIII		HSM Management Services, Inc.	0.00%	8,974	8,974		19	
20	V	34	See Schedule VIII		HSM Management Services, Inc.	0.00%	10,650	10,650		20	
21	V	19	See Schedule VIII		HSM Management Services, Inc.	0.00%	31,467	31,467		21	
22	V	26	See Schedule VIII		HSM Management Services, Inc.	0.00%	6,754	6,754		22	
23	V	6	See Schedule VIII		HSM Management Services, Inc.	0.00%	32,120	32,120		23	
24	V	20	See Schedule VIII		HSM Management Services, Inc.	0.00%	922	922		24	
25	V									25	
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	583	583		26	
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	651	651		27	
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	27,241	27,241		28	
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	14,063	14,063		29	
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	348	348		30	
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	27,412	27,412		31	
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	3,642	3,642		32	
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,239	1,239		33	
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,695	1,695		34	
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	2,074	2,074		35	
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	461	461		36	
37	V									37	
38	V									38	
39	Total			\$			\$ 507,931	\$ * 507,931		39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

## 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	Larry Vander Maten	President	Management	75.00%	1,045,274	2	5.82%	Salary	\$ 64,639	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	457,728	2	5.82%	Salary	28,305	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,944		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 Galesburg

# 0032805

Report Period Beginning: 7/1/2005

Ending: 7/30/2006

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 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	17	Salaries - Officers	Total Cost 85,233,641	18	\$ 1,128,195	\$ 1,128,195	4,963,793	\$ 65,703	1
2	21	Salaries - Others	Total Cost 85,233,641	18	2,665,906	2,665,906	4,963,793	155,256	2
3	22	Payroll Taxes	Total Cost 85,233,641	18	251,062		4,963,793	14,621	3
4	22	Employee Benefits	Total Cost 85,233,641	18	102,624		4,963,793	5,977	4
5	25	Travel	Total Cost 85,233,641	18	230,054		4,963,793	13,398	5
6	30	Depreciation	Total Cost 85,233,641	18	154,087		4,963,793	8,974	6
7	34	Building Rent	Total Cost 85,233,641	18	182,875		4,963,793	10,650	7
8	19	Professional Services	Total Cost 85,233,641	18	540,314		4,963,793	31,467	8
9	21	Telephone	Total Cost 85,233,641	18	175,406		4,963,793	10,215	9
10	26	Insurance	Total Cost 85,233,641	18	115,979		4,963,793	6,754	10
11	21	Taxes, Licenses, & Ofc. Sup.	Total Cost 85,233,641	18	203,759		4,963,793	11,866	11
12	6	Maintenance	Total Cost 85,233,641	18	100,147		4,963,793	5,832	12
13	20	Dues & Subscriptions	Total Cost 85,233,641	18	15,838		4,963,793	922	13
14	17	Direct - Admin	Direct Cost 1	1	56,515	56,515	1	56,515	14
15	17	Direct - Admin	Direct Cost 17	17	857,166	857,166	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost 1	1	4,084		1	4,084	16
17	22	Direct - Payroll Taxes	Direct Cost 17	17	62,861		0	0	17
18	30	Direct - Depreciation	Direct Cost 1	1	0		1	0	18
19	30	Direct - Depreciation	Direct Cost 17	17	575		0	0	19
20	25	Direct - Travel	Direct Cost 1	1	0		1	0	20
21	25	Direct - Travel	Direct Cost 17	17	238		0	0	21
22	6	Direct - Maintenance	Direct Cost 1	1	26,288		1	26,288	22
23	6	Direct - Maintenance	Direct Cost 17	17	311,301		0	0	23
24									24
25	TOTALS				\$ 7,185,274	\$ 4,707,782		\$ 428,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning: 7/1/2005

Ending: 7/30/2006

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

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

Name of Related Organization Midwest Administrative Services, Inc.  
 Street Address 11701 Borman Drive, Suite 315  
 City / State / Zip Code St. Louis, MO 63146  
 Phone Number (314) 994-9070  
 Fax Number (314) 994-9912

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	\$ 10,015	\$ 10,015	4,963,793	\$ 583	1
2	6	Maintenance	Total Cost	18	11,176		4,963,793	651	2
3	17	Salaries - Officers	Total Cost	18	467,751	467,751	4,963,793	27,241	3
4	19	Professional Services	Total Cost	18	241,473		4,963,793	14,063	4
5	20	Dues & Subscriptions	Total Cost	18	5,983		4,963,793	348	5
6	21	Salaries - Others	Total Cost	18	400,855	400,855	4,963,793	23,345	6
7	21	Clerical & Office Supplies	Total Cost	18	69,834		4,963,793	4,067	7
8	22	Payroll Taxes & Emp Ben.	Total Cost	18	62,532		4,963,793	3,642	8
9	25	Travel	Total Cost	18	21,283		4,963,793	1,239	9
10	26	Insurance	Total Cost	18	29,099		4,963,793	1,695	10
11	30	Depreciation	Total Cost	18	30,041		4,963,793	1,750	11
12	34	Building Rent	Total Cost	18	7,908		4,963,793	461	12
13	17	Direct - Admin Salaries	Direct Cost	1			1		13
14	17	Direct - Admin Salaries	Direct Cost	17	21,416	21,416			14
15	30	Direct - Depreciation	Direct Cost	1	324		1	324	15
16	30	Direct - Depreciation	Direct Cost	17	5,098				16
17	6	Direct - Maintenance	Direct Cost	1			1		17
18	6	Direct - Maintenance	Direct Cost	17	3,787				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,388,575	\$ 900,037		\$ 79,409	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Reliance Bank		X	Refinance Mortgage	Varies	5/3/05	\$ 12,000,000	\$ 12,000,000	5/2/07	Prm-3/8	\$ 829,000	1								
2	Less Related Party Interest Offset										(240,331)	2								
3	Less Interest Income Offset										(9,697)	3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 12,000,000	\$ 12,000,000			\$ 578,972	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 12,000,000	\$ 12,000,000			\$ 578,972	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**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 Rosewood Care Center Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0032805

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 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>99-04-251-012</u>	<u>Rosewood Sub Lots 2 &amp; 3</u>	\$ <u>142,257.76</u>	\$ <u>142,257.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>142,257.76</u>	\$ <u>142,257.76</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 Rosewood Care Center Galesburg

# 0032805 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>5 acres</u>	<u>1987</u>	<u>\$ 85,594</u>	<u>1</u>
2		<u>6/90 Audit</u>		<u>(1,344)</u>	<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 84,250</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1987	\$ 2,304,765	\$	15-25	\$ 89,355	\$ 89,355	\$ 1,889,950	4
5	60			1998	2,243,326		25	89,733	89,733	695,431	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	6/90 Audit Adjustment			1987	6,600		25	264	264	3,960	9
10	18 Bed Addition			1989	27,565		15-25	600	600	22,765	10
11	Painting			1991	1,360		5			1,360	11
12	Painting			1992	1,520		5			1,520	12
13	Roof Vents			1992	6,896		25	276	276	3,933	13
14	Seeding/Landscaping/Berm			1988	32,414		25	1,297	1,297	23,124	14
15	Parking Lot Improvements			1992	5,673		25	227	227	3,159	15
16	Irrigation System			1994	7,253		10			7,253	16
17	Landscaping			1998	3,183		10	318	318	2,545	17
18	Facility Signage			1987	7,572		10			7,572	18
19	Hot Water Booster/Sinks			1987	4,606		10			4,606	19
20	Exhaust Hood & Fire Suppression System			1987	9,019		10			9,019	20
21	Carpet			1987	11,131		5			11,131	21
22	Nurse Call System & Paging System			1987	45,340		15			45,340	22
23	Nurse Call Addition			1988	1,643		10			1,643	23
24	Facility Signage			1991	5,133		10			5,133	24
25	Facility Signage			1992	1,000		10			1,000	25
26	Water heaters			1992	3,123		10			3,123	26
27	Shingle Roof Replacement			2002	102,091		40	2,552	2,552	11,698	27
28	Seal & Restripe Parking Lot			2003	14,545		25	582	582	1,649	28
29	Repair Soffit & Facia on Gables			2003	5,394		40	135	135	348	29
30	Air Conditioning Unit & Heat Pumps			2003	9,817		10	982	982	2,666	30
31	Boiler			2003	20,269		10	2,027	2,027	5,236	31
32	Heat Pumps			2004	2,875		10	287	287	670	32
33	Paint Exterior of Building			2005	2,874		10	287	287	383	33
34	Fire Alarm Panel			2005	2,647		10	221	221	221	34
35	Console Heat Pumps			2006	6,337		10	158	158	158	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Leasehold Improvements - Facility:		\$	\$		\$	\$	\$	37
38	Tiling/Dumpster Slabs/Guards/Painting	1993	20,103		7			20,103	38
39	Painting	1994	5,677		7			5,677	39
40	Painting/Base Stripping/Wallpaper/Carpet	1995	37,273		7			37,273	40
41	Wallpaper/Tiling/Painting	1996	10,392		7			10,392	41
42	Drapes/Sterling Textile/Fahlunds/Painting/Decorating	1998	15,318	273	7	273		15,318	42
43	Redline - Mat	1999	605	72	7	72		605	43
44	Computer Cabling	2000	2,895	414	7	414		2,310	44
45	Computer Cabling	2001	214	31	7	31		169	45
46	Wallpaper	2001	6,197	886	7	886		4,708	46
47	Dietary Door/Frame & Door	2002	5,105	728	7	728		3,464	47
48	Backflow Preventers/New Piping	2005	8,158	1,165	7	1,165		1,359	48
49	Painting	2005	3,855	551	7	551		551	49
50	Vinyl Wallcovering	2005	6,580	626	7	626		626	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)		\$ 5,018,343	\$ 4,746		\$ 194,047	\$ 189,301	\$ 2,869,151	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 327,570	\$ 333	\$ 21,127	\$ 20,794	15-25 Yrs	\$ 125,113	71
72	Current Year Purchases	26,748		1,322	1,322	10 Yrs	1,322	72
73	Fully Depreciated Assets	379,512					379,512	73
74								74
75	TOTALS	\$ 733,830	\$ 333	\$ 22,449	\$ 22,116		\$ 505,947	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	\$	\$	\$ 4,404	\$ 4,404	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	13,736		751	751	4 Yrs	751	77
78	Senior Living Services	Various	2006	2,808		176	176	4 Yrs	176	78
79										79
80	TOTALS			\$ 16,544	\$	\$ 5,331	\$ 5,331		\$ 927	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,852,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,079	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,827	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 216,748	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,376,025	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Schedule Not Applicable

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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)	
<b>TOTAL TRAINED</b>	

- (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	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	10a-8	hrs	\$	9,531	\$ 160,513	\$	9,531	\$ 160,513	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		887	33,507		887	33,507	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		10,162	91,380	1,567	10,162	92,947	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				74,288		74,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, X-Ray Other (specify): & Enterals	39-8				20,031	14,158		34,189	13
14	TOTAL			\$	20,580	\$ 305,431	\$ 90,013	20,580	\$ 395,444	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 Galesburg# 0032805Report Period Beginning: 7/1/2005

Ending:

6/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (687,206)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u> )	759,583		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,847		6
7	Other Prepaid Expenses	10,671		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 93,895	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	124,704		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(104,040)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 20,664	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 114,559	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 111,153	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	175,372		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,666		31
32	Accrued Real Estate Taxes(Sch.IX-B)	143,681		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(132,800)		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 339,072	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 339,072	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (224,513)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 114,559	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>29,117</b>	<b>1</b>
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>29,117</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(253,630)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(253,630)</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(224,513)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg# 0032805Report Period Beginning: 7/1/2005Ending: 6/30/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,004,118	1
2	Discounts and Allowances for all Levels	(971,983)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,032,135	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	913,698	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 913,698	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,475	13
14	Non-Patient Meals	5,615	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,090	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	9,697	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,697	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	1,874	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,874	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,965,494	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	894,366	31
32	Health Care	2,451,699	32
33	General Administration	808,696	33
<b>B. Capital Expense</b>			
34	Ownership	991,736	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	108,477	35
36	Provider Participation Fee	98,550	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,353,524	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(388,030)	41
42	<b>Income Taxes</b>	134,400	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (253,630)	43

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

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

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

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

Facility Name & ID Number Rosewood Care Center Galesburg

# 0032805

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

**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	2,052	2,186	\$ 57,919	\$ 26.50	1
2	Assistant Director of Nursing	1,560	1,662	40,858	24.58	2
3	Registered Nurses	14,576	15,526	367,920	23.70	3
4	Licensed Practical Nurses	20,671	22,018	378,673	17.20	4
5	CNAs & Orderlies	84,446	89,952	837,935	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,500	4,793	72,474	15.12	8
9	Activity Director					9
10	Activity Assistants	5,117	5,450	44,165	8.10	10
11	Social Service Workers	4,195	4,468	51,379	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,314	22,703	201,901	8.89	15
16	Dishwashers					16
17	Maintenance Workers	2,183	2,325	23,955	10.30	17
18	Housekeepers	17,878	19,044	150,280	7.89	18
19	Laundry	5,137	5,472	50,818	9.29	19
20	Administrator	421	449	16,773	37.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,912	12,688	143,346	11.30	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	4,930	5,252	64,188	12.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,892	213,988	\$ 2,502,584 *	\$ 11.69	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	312	\$ 7,168	1-3	35
36	Medical Director	Contract	9,875	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	135	2,400	11-3	44
45	Social Service Consultant	135	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	582	\$ 21,843		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	152	\$ 5,620	50
51	Licensed Practical Nurses	2,627	88,257	51
52	Certified Nurse Assistants/Aides	151	3,125	52
53	TOTAL (lines 50 - 52)	2,930	\$ 97,002	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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association - \$9,936
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,029 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. \$ 98,550  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,615
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF GALESBURG  
IDPH ID #0032805  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 4,159</u>
	<u>\$ 4,159</u>

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

ROSEWOOD CARE CENTER OF GALESBURG  
IDPH ID #0032805  
ATTACHMENT TO SCHEDULE VII, SECTION A.  
6/30/2006

RELATED NURSING HOME:

CITY:

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

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
MIDWEST ADMINISTRATIVE SERVICES, INC.	ADMINISTRATIVE CO.
GALESBURG REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY
SENIOR LIVING SERVICES, INC.	BLDG SERVICES CO.