

Facility Name & ID Number Rosewood Care Center Inverness

0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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>142</u>	Skilled (SNF)	<u>142</u>	<u>51,830</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>142</u>	TOTALS	<u>142</u>	<u>51,830</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>11,884</u>	<u>11,884</u>	8
9	SNF/PED					9
10	ICF	<u>4,425</u>	<u>23,350</u>		<u>27,775</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,425</u>	<u>23,350</u>	<u>11,884</u>	<u>39,659</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.52%

D. How many bed-hold days during this year were paid by the Department? 106 (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 4/11/2000

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

YES Date 4/11/2000 NO

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

YES NO If YES, enter number of beds certified 58 and days of care provided 11,884

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 Inverness # 0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	218,901	21,493	7,728	248,122		248,122	816	248,938		1
2	Food Purchase		169,037		169,037		169,037	(5,392)	163,645		2
3	Housekeeping	172,541	47,005		219,546		219,546		219,546		3
4	Laundry	54,037	15,660		69,697		69,697		69,697		4
5	Heat and Other Utilities			160,021	160,021		160,021		160,021		5
6	Maintenance	25,871	7,114	188,679	221,664		221,664	(32,595)	189,069		6
7	Other (specify):* Sanitation			9,877	9,877		9,877		9,877		7
8	TOTAL General Services	471,350	260,309	366,305	1,097,964		1,097,964	(37,171)	1,060,793		8
	B. Health Care and Programs										
9	Medical Director			20,685	20,685		20,685		20,685		9
10	Nursing and Medical Records	2,538,852	220,507	184,410	2,943,769		2,943,769		2,943,769		10
10a	Therapy	72,244	2,508	583,015	657,767		657,767	100,731	758,498		10a
11	Activities	48,784	4,889	2,304	55,977		55,977		55,977		11
12	Social Services	58,402		2,237	60,639		60,639		60,639		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,718,282	227,904	792,651	3,738,837		3,738,837	100,731	3,839,568		16
	C. General Administration										
17	Administrative	10,784		647,149	657,933		657,933	(489,006)	168,927		17
18	Directors Fees										18
19	Professional Services			9,507	9,507		9,507	63,695	73,202		19
20	Dues, Fees, Subscriptions & Promotions			44,147	44,147	1,990	46,137	(5,785)	40,352		20
21	Clerical & General Office Expenses	172,629	34,896	28,531	236,056		236,056	200,956	437,012		21
22	Employee Benefits & Payroll Taxes			394,207	394,207		394,207	35,943	430,150		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,536	2,536	(1,990)	546		546		24
25	Other Admin. Staff Transportation			12,039	12,039		12,039	20,477	32,516		25
26	Insurance-Prop.Liab.Malpractice			66,528	66,528		66,528	17,611	84,139		26
27	Other (specify):*										27
28	TOTAL General Administration	183,413	34,896	1,204,644	1,422,953		1,422,953	(156,109)	1,266,844		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,373,045	523,109	2,363,600	6,259,754		6,259,754	(92,549)	6,167,205		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Inverness #0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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			3,355	3,355		3,355	299,546	302,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			202,228	202,228		202,228	232,646	434,874			32
33	Real Estate Taxes			598,822	598,822		598,822		598,822			33
34	Rent-Facility & Grounds			1,663,415	1,663,415		1,663,415	(1,647,872)	15,543			34
35	Rent-Equipment & Vehicles			39,641	39,641		39,641		39,641			35
36	Other (specify):* Mortgage Insur.							71,936	71,936			36
37	TOTAL Ownership			2,507,461	2,507,461		2,507,461	(1,043,744)	1,463,717			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		345,894	54,218	400,112		400,112		400,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,745	77,745		77,745		77,745			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		345,894	131,963	477,857		477,857		477,857			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,373,045	869,003	5,003,024	9,245,072		9,245,072	(1,136,293)	8,108,779			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 Inverness

0041616

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	(4,899)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,019)	21		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	(25,012)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(493)	2		13
14	Non-Care Related Interest	(202,228)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				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	(2,642)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,920)	20		28
29	Other-Attach Schedule Marketing Salary	(70,466)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (325,679)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(810,614)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (810,614)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,136,293)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Inverness

ID# 0041616

Report Period Beginning: 7/1/05

Ending: 6/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$ (70,466)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(70,466)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Inverness

0041616

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	816	0	0	0	0	0	0	0	0	816	1
2	Food Purchase	(5,392)	0	0	0	0	0	0	0	0	0	0	(5,392)	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	(65,712)	33,117	0	0	0	0	0	0	0	0	(32,595)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,392)	(65,712)	33,933	0	(37,171)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	100,731	0	0	0	0	0	0	0	0	0	100,731	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	100,731	0	0	0	0	0	0	0	0	0	100,731	16
	C. General Administration													
17	Administrative	0	(647,149)	158,143	0	0	0	0	0	0	0	0	(489,006)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	63,695	0	0	0	0	0	0	0	0	63,695	19
20	Fees, Subscriptions & Promotions	(7,562)	0	1,777	0	0	0	0	0	0	0	0	(5,785)	20
21	Clerical & General Office Expenses	(85,485)	0	286,441	0	0	0	0	0	0	0	0	200,956	21
22	Employee Benefits & Payroll Taxes	0	0	35,943	0	0	0	0	0	0	0	0	35,943	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	20,477	0	0	0	0	0	0	0	0	20,477	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	11,820	0	0	0	0	0	0	0	0	17,611	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(93,047)	(641,358)	578,296	0	(156,109)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98,439)	(606,339)	612,229	0	(92,549)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Inverness

0041616 Report Period Beginning:

7/1/05 Ending:

6/30/06

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	284,245	15,301	0	0	0	0	0	0	0	0	299,546	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(227,240)	459,886	0	0	0	0	0	0	0	0	0	232,646	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,663,415)	15,543	0	0	0	0	0	0	0	0	(1,647,872)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	71,936	0	0	0	0	0	0	0	0	0	71,936	36
37	TOTAL Ownership	(227,240)	(847,348)	30,844	0	(1,043,744)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(325,679)	(1,453,687)	643,073	0	(1,136,293)	45							

Facility Name & ID Number Rosewood Care Center Inverness

0041616

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	\$ 532,697	HSM Management Services, Inc.	0.00%	\$	\$ (532,697)	1
2	V	17 Administration Fee	114,452	Midwest Administrative Services, Inc.	0.00%		(114,452)	2
3	V	10a Therapy	583,015	Rosewood Therapy Services, Inc.	0.00%	683,746	100,731	3
4	V							4
5	V	34 Rent	1,663,415	Inverness Real Estate, Inc.	0.00%		(1,663,415)	5
6	V	30 Depreciation		Inverness Real Estate, Inc.	0.00%	283,999	283,999	6
7	V	32 Interest		Inverness Real Estate, Inc.	0.00%	459,886	459,886	7
8	V	36 Mortgage Insurance		Inverness Real Estate, Inc.	0.00%	71,936	71,936	8
9	V	26 Property Insurance		Inverness Real Estate, Inc.	0.00%	5,791	5,791	9
10	V							10
11	V	6 Repair & Maintenance	73,393	Senior Living Services, Inc.	0.00%	7,681	(65,712)	11
12	V	30 Depreciation		Senior Living Services, Inc.	0.00%	246	246	12
13	V							13
14	Total		\$ 2,966,972			\$ 1,513,285	\$ * (1,453,687)	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 Inverness# 0041616Report Period Beginning: 7/1/05Ending: 6/30/06

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%	\$ 120,034	\$ 120,034	15	
16	V	21	See Schedule VIII		HSM Management Services, Inc.		0.00%	248,092	248,092	16	
17	V	22	See Schedule VIII		HSM Management Services, Inc.		0.00%	30,848	30,848	17	
18	V	25	See Schedule VIII		HSM Management Services, Inc.		0.00%	18,743	18,743	18	
19	V	30	See Schedule VIII		HSM Management Services, Inc.		0.00%	12,554	12,554	19	
20	V	34	See Schedule VIII		HSM Management Services, Inc.		0.00%	14,899	14,899	20	
21	V	19	See Schedule VIII		HSM Management Services, Inc.		0.00%	44,021	44,021	21	
22	V	26	See Schedule VIII		HSM Management Services, Inc.		0.00%	9,449	9,449	22	
23	V	6	See Schedule VIII		HSM Management Services, Inc.		0.00%	31,860	31,860	23	
24	V	20	See Schedule VIII		HSM Management Services, Inc.		0.00%	1,290	1,290	24	
25	V									25	
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	816	816	26	
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	1,257	1,257	27	
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	38,109	38,109	28	
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	19,674	19,674	29	
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	487	487	30	
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	38,349	38,349	31	
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	5,095	5,095	32	
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	1,734	1,734	33	
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	2,371	2,371	34	
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	2,747	2,747	35	
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	644	644	36	
37	V									37	
38	V									38	
39	Total			\$				\$ 643,073	\$ * 643,073	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 Inverness # 0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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%	1,019,484	3	8.15%	Salary	\$ 90,428	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	446,434	3	8.15%	Salary	39,599	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	\$ 130,027		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 Inverness

0041616

Report Period Beginning:

7/1/05

Ending: 6/30/06

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	\$ 6,944,260	\$ 91,918	1
2	21	Salaries - Others	Total Cost	85,233,641	18	2,665,906	6,944,260	217,200	2
3	22	Payroll Taxes	Total Cost	85,233,641	18	251,062	6,944,260	20,455	3
4	22	Employee Benefits	Total Cost	85,233,641	18	102,624	6,944,260	8,361	4
5	25	Travel	Total Cost	85,233,641	18	230,054	6,944,260	18,743	5
6	30	Depreciation	Total Cost	85,233,641	18	154,087	6,944,260	12,554	6
7	34	Building Rent	Total Cost	85,233,641	18	182,875	6,944,260	14,899	7
8	19	Professional Services	Total Cost	85,233,641	18	540,314	6,944,260	44,021	8
9	21	Telephone	Total Cost	85,233,641	18	175,406	6,944,260	14,291	9
10	26	Insurance	Total Cost	85,233,641	18	115,979	6,944,260	9,449	10
11	21	Taxes, License, & Ofc. Supplies	Total Cost	85,233,641	18	203,759	6,944,260	16,601	11
12	6	Maintenance	Total Cost	85,233,641	18	100,147	6,944,260	8,159	12
13	20	Dues & Subscriptions	Total Cost	85,233,641	18	15,838	6,944,260	1,290	13
14	17	Direct - Admin	Direct Cost	1	1	28,116	28,116	1	28,116
15	17	Direct - Admin	Direct Cost	17	17	885,565	885,565	0	0
16	22	Direct - Payroll Taxes	Direct Cost	1	1	2,032	1	2,032	16
17	22	Direct - Payroll Taxes	Direct Cost	17	17	64,913	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	23,701	1	23,701	22
23	6	Direct - Maintenance	Direct Cost	17	17	313,888	0	0	23
24									24
25	TOTALS					\$ 7,185,274	\$ 4,707,782	\$ 531,790	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Inverness

0041616

Report Period Beginning:

7/1/05

Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Total Cost	85,233,641	18	\$ 10,015	\$ 10,015	6,944,260	\$ 816	1
2	6	Maintenance	Total Cost	85,233,641	18	11,176	6,944,260	6,944,260	911	2
3	17	Salaries - Officers	Total Cost	85,233,641	18	467,751	467,751	6,944,260	38,109	3
4	19	Professional Services	Total Cost	85,233,641	18	241,473	6,944,260	6,944,260	19,674	4
5	20	Dues & Subscriptions	Total Cost	85,233,641	18	5,983	6,944,260	6,944,260	487	5
6	21	Salaries - Other	Total Cost	85,233,641	18	400,855	400,855	6,944,260	32,659	6
7	21	Clerical & Office Supplies	Total Cost	85,233,641	18	69,834	6,944,260	6,944,260	5,690	7
8	22	Payroll Taxes & Empl. Benefits	Total Cost	85,233,641	18	62,532	6,944,260	6,944,260	5,095	8
9	25	Travel	Total Cost	85,233,641	18	21,283	6,944,260	6,944,260	1,734	9
10	26	Insurance	Total Cost	85,233,641	18	29,099	6,944,260	6,944,260	2,371	10
11	30	Depreciation	Total Cost	85,233,641	18	30,041	6,944,260	6,944,260	2,448	11
12	34	Building Rent	Total Cost	85,233,641	18	7,908	6,944,260	6,944,260	644	12
13	17	Direct - Admin Salaries	Direct Cost	1	1			1		13
14	17	Direct - Admin Salaries	Direct Cost	17	17	21,416	21,416			14
15	30	Direct - Depreciation	Direct Cost	1	1	299		1	299	15
16	30	Direct - Depreciation	Direct Cost	17	17	5,123				16
17	6	Direct - Maintenance	Direct Cost	1	1	346		1	346	17
18	6	Direct - Maintenance	Direct Cost	17	17	3,441				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,388,575	\$ 900,037		\$ 111,283	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			
A. Directly Facility Related																				
Long-Term																				
1	Capmark		X	Refinance Mortgage	\$70,242.00	10/1/04	\$ 14,387,100	\$ 14,108,534	11/1/39	4.74%	\$ 673,135	1								
2	Less: Related Party Interest Income Offset										(217,514)	2								
3	Interest Income										(25,012)	3								
4	Amortization of Loan Costs										5,224	4								
5	Real Estate Company Interest Income										(959)	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$70,242.00		\$ 14,387,100	\$ 14,108,534			\$ 434,874	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 14,387,100	\$ 14,108,534			\$ 434,874	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 71,936 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Inverness# 0041616 Report Period Beginning: 7/1/05Ending: 6/30/06

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.			\$	490,069	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.)			\$	484,896	2																				
3.	Under or (over) accrual (line 2 minus line 1).			\$	(5,173)	3																				
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	603,995	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.			\$	598,822	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:																										
	2001	328,408	8	<table border="1"> <thead> <tr> <th colspan="4">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>			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
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																							
	2002	513,197	9																							
	2003	582,283	10																							
	2004	517,358	11																							
	2005	571,308	12																							
2004 Taxes Paid = \$226,216																										
2005 Taxes Paid = \$258,680																										
Accrual = Remaining balance of 2005 tax bill (312,628) + 1/2 of estimated 2006 tax bill (291,367)																										

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Inverness COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041616

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>02-28-301-017-0000</u>	<u>1800 Colonial Pky, Inverness 5-97</u>	\$ <u>570,689.29</u>	\$ <u>570,689.29</u>
2. <u>02-28-301-039-0000</u>	<u>1800 Colonial Pky, Inverness 1-00</u>	\$ <u>618.24</u>	\$ <u>618.24</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>571,307.53</u>	\$ <u>571,307.53</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 Inverness

0041616 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,690 B. General Construction Type: Exterior Brick Veneer 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>1,382,237</u>	1
2					2
3	TOTALS			\$ <u>1,382,237</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041616

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	142			2000	\$ 7,960,398	\$	40	\$ 199,010	\$ 199,010	\$ 1,243,812	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Development			2000	386,532		25	15,461	15,461	96,632	9
10	Monument Sign			2003	2,200		10	220	220	770	10
11	Road and Monument Signs			2002	3,294		10	329	329	1,453	11
12	Seal Coat & Stripe Parking Lot			2004	4,957		2	2,479	2,479	4,338	12
13	Emergency Generator Load Bank			2005	3,942		12	274	274	274	13
14	A/C Unit			2005	10,407		10	694	694	694	14
15	Heat Pumps			2006	3,447		10	86	86	86	15
16											16
17											17
18											18
19											19
20											20
21	Facility Leaseholds:										21
22	Computer Cabling			2001	2,895	414	7	414		2,275	22
23	Shelving			2001	2,371	338	7	338		1,608	23
24	Curtains for Dining Room			2004	2,598	371	7	371		588	24
25	Carpet in Patient Lounges			2005	14,025	2,004	7	2,004		2,338	25
26	Smoke Dampers			2006	3,191	228	7	228		228	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0041616

Report Period Beginning:

7/1/05

Ending:

6/30/06

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)	\$	\$ 8,400,257	\$ 3,355	\$ 221,908	\$ 218,553	\$ 1,355,096	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Inverness # 0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	\$ 624,447	\$	\$ 68,837	\$ 68,837	5-10 Yrs	\$ 378,883	71
72	Current Year Purchases	67,550		4,698	4,698	5-10 Yrs	4,698	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 691,997	\$	\$ 73,535	\$ 73,535		\$ 383,581	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 Svcs	Various	Various	\$	\$	\$ 6,161	\$ 6,161	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	19,217		1,051	1,051	4 Yrs	1,051	77
78	Senior Living Svcs, Inc.	Various	2006	3,929		246	246	4 Yrs	246	78
79										79
80	TOTALS			\$ 23,146	\$	\$ 7,458	\$ 7,458		\$ 1,297	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)	\$ 10,497,637	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 302,901	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 299,546	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,739,974	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	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Rosewood Care Center Inverness # 0041616 Report Period Beginning: 7/1/05 Ending: 6/30/06

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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	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	\$	19,392	\$ 251,985	\$	19,392	\$ 251,985	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,652	57,656		1,652	57,656	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		26,790	374,105	2,508	26,790	376,613	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				320,401		320,401	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals Other (specify): & X-Ray	39-8				54,218	25,493		79,711	13
14	TOTAL			\$	47,834	\$ 737,964	\$ 348,402	47,834	\$ 1,086,366	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 Inverness# 0041616Report Period Beginning: 7/1/05

Ending:

6/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 277,467	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>105,000</u>)	785,653		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,417		6
7	Other Prepaid Expenses	17,247		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Admin. Fees</u>	294,600		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,385,384	\$	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	25,080		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(7,037)		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)	\$ 18,043	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,403,427	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,704	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,727,136		29
30	Accrued Salaries Payable	204,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,554		31
32	Accrued Real Estate Taxes(Sch.IX-B)	603,995		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	92,100		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,899,541	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,899,541	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,496,114)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,403,427	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,553,779)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,553,779)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	169,665	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	(112,000)	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)	\$ 57,665	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,496,114)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Inverness

0041616

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	\$ 9,971,779	1
2	Discounts and Allowances for all Levels	(2,782,243)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,189,536	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,271,362	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,271,362	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	2,100	13
14	Non-Patient Meals	4,899	14
15	Telephone, Television and Radio	15,019	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)	\$ 22,018	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,012	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,012	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	2,963	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,963	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,510,891	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,097,964	31
32	Health Care	3,738,837	32
33	General Administration	1,422,953	33
B. Capital Expense			
34	Ownership	2,507,461	34
C. Ancillary Expense			
35	Special Cost Centers	400,112	35
36	Provider Participation Fee	77,745	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,245,072	40
41	Income before Income Taxes (line 30 minus line 40)**	265,819	41
42	Income Taxes	(96,154)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 169,665	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 Inverness

0041616

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	816	859	\$ 27,365	\$ 31.86	1
2	Assistant Director of Nursing	1,092	1,149	28,867	25.12	2
3	Registered Nurses	42,681	44,943	1,393,255	31.00	3
4	Licensed Practical Nurses	2,157	2,271	45,658	20.10	4
5	CNAs & Orderlies	76,795	80,866	996,587	12.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,278	3,452	72,244	20.93	8
9	Activity Director					9
10	Activity Assistants	4,672	4,920	48,784	9.92	10
11	Social Service Workers	3,637	3,830	58,402	15.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,126	22,246	218,901	9.84	15
16	Dishwashers					16
17	Maintenance Workers	2,068	2,178	25,871	11.88	17
18	Housekeepers	18,436	19,414	172,541	8.89	18
19	Laundry	6,460	6,802	54,037	7.94	19
20	Administrator	288	303	10,784	35.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,633	13,308	172,629	12.97	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	3,369	3,547	47,120	13.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,508	210,088	\$ 3,373,045 *	\$ 16.06	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	97	\$ 7,728	1-3	35
36	Medical Director	Contract	20,685	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	130	2,304	11-3	44
45	Social Service Consultant	125	2,237	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	352	\$ 32,954		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,129	\$ 147,034	10-3	50
51	Licensed Practical Nurses	999	37,376	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,128	\$ 184,410		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Inverness

0041616

Report Period Beginning: 7/1/05

Ending: 6/30/06

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		
Total Administrator Cost on Line 17, Col. 1:				Workers' Compensation Insurance	\$ 86,142	IDPH License Fee	\$ 1,990		
Harry Poole	Administrator	0.00%	10,784	Unemployment Compensation Insurance	40,015	Advertising: Employee Recruitment	27,058		
Total Direct Administrator Cost from HSM Mgmt - Line 17, col. 7				FICA Taxes	255,959	Health Care Worker Background Check			
Irene Glass	Administrator	0.00%	28,116	Employee Health Insurance	6,458	(Indicate # of checks performed <u>66</u>)	660		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Meals		Patient Background Checks	200		
(List each licensed administrator separately.)				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	4,562		
B. Administrative - Other				Related Party Allocations	35,943	Misc. Dues/Subscriptions	8,667		
Description			Amount	Employee Uniforms	504	Related Party Allocation	1,777		
Management Fees			\$ 532,697	Employee Relations	2,686				
Administrative Fees			114,452	Employee Physicals	1,693	Less: Public Relations Expense	(51)		
TOTAL (agree to Schedule V, line 17, col. 3)				Recruitment Fees	750	Non-allowable advertising	(2,591)		
(Attach a copy of any management service agreement)						Yellow page advertising	(1,920)		
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)	\$ 430,150	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,352		
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
C.J. Schlosser & Company	Accountant/Consultant		\$ 9,407	Description	Line #	Amount	G. Schedule of Travel and Seminar**		
	Legal		100	Section Not Applicable		\$	Description	Amount	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 9,507				Out-of-State Travel	\$
								In-State Travel	
								Seminar Expense	546
								Entertainment Expense	()
								(agree to Sch. V, line 24, col. 8)	
								TOTAL	\$ 546

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Rosewood Care Center Inverness

Report Period Beginning: 7/1/05 Ending: 6/30/06

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. IHCA - \$7,838
- (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. \$ 73,928 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. \$ 77,745
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? Yes Indicate the amount. \$ 4,899
- (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? N/A 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 INVERNESS
RECLASSIFICATIONS
MEDICAID COST REPORT
6/30/06

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(1,990)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	1,990	20

ROSEWOOD CARE CENTER OF INVERNESS
IDPH ID #0041616
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 12,039</u>
	<u><u>\$ 12,039</u></u>

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

ROSEWOOD CARE CENTER OF INVERNESS INC.
IDPH ID #0041616
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 GALESBURG	GALESBURG, 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.
INVERNESS REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
SENIOR LIVING SERVICES, INC.	BLDG SERVICES, CO.
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY