

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006 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>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</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>139</u>	TOTALS	<u>139</u>	<u>50,735</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>9,668</u>	<u>9,668</u>	8
9	SNF/PED					9
10	ICF	<u>11,133</u>	<u>21,180</u>		<u>32,313</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,133</u>	<u>21,180</u>	<u>9,668</u>	<u>41,981</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.75%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. 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 11/4/1994

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

YES Date 11/4/1994 NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 9,668Medicare 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 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	
	A. General Services											
1	Dietary	214,713	22,828	10,596	248,137		248,137	725	248,862			1
2	Food Purchase		184,633		184,633		184,633	(3,917)	180,716			2
3	Housekeeping	155,014	33,748		188,762		188,762		188,762			3
4	Laundry	36,239	12,329		48,568		48,568		48,568			4
5	Heat and Other Utilities			171,013	171,013		171,013		171,013			5
6	Maintenance	25,477	6,454	236,582	268,513		268,513	(48,457)	220,056			6
7	Other (specify):* Sanitation			20,349	20,349		20,349		20,349			7
8	TOTAL General Services	431,443	259,992	438,540	1,129,975		1,129,975	(51,649)	1,078,326			8
	B. Health Care and Programs											
9	Medical Director			3,230	3,230		3,230		3,230			9
10	Nursing and Medical Records	2,477,525	237,828	55,069	2,770,422		2,770,422		2,770,422			10
10a	Therapy	96,572	490	459,817	556,879		556,879	72,004	628,883			10a
11	Activities	58,506	4,164	1,536	64,206		64,206		64,206			11
12	Social Services	64,516		2,584	67,100		67,100		67,100			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,697,119	242,482	522,236	3,461,837		3,461,837	72,004	3,533,841			16
	C. General Administration											
17	Administrative	14,831		603,147	617,978		617,978	(439,963)	178,015			17
18	Directors Fees											18
19	Professional Services			8,270	8,270		8,270	56,593	64,863			19
20	Dues, Fees, Subscriptions & Promotions			44,228	44,228	995	45,223	(7,760)	37,463			20
21	Clerical & General Office Expenses	165,528	40,165	19,571	225,264		225,264	190,334	415,598			21
22	Employee Benefits & Payroll Taxes			414,546	414,546		414,546	33,574	448,120			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,757	2,757	(995)	1,762		1,762			24
25	Other Admin. Staff Transportation			4,001	4,001		4,001	18,194	22,195			25
26	Insurance-Prop.Liab.Malpractice			62,896	62,896		62,896	16,293	79,189			26
27	Other (specify):*											27
28	TOTAL General Administration	180,359	40,165	1,159,416	1,379,940		1,379,940	(132,735)	1,247,205			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,308,921	542,639	2,120,192	5,971,752		5,971,752	(112,380)	5,859,372			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,673	7,673		7,673	160,012	167,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							503,401	503,401			32
33	Real Estate Taxes			120,859	120,859		120,859		120,859			33
34	Rent-Facility & Grounds			1,532,378	1,532,378		1,532,378	(1,518,568)	13,810			34
35	Rent-Equipment & Vehicles			14,040	14,040		14,040		14,040			35
36	Other (specify):* Mortgage Insur.							70,555	70,555			36
37	TOTAL Ownership			1,674,950	1,674,950		1,674,950	(784,600)	890,350			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		264,546	44,447	308,993		308,993		308,993			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		264,546	120,550	385,096		385,096		385,096			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,308,921	807,185	3,915,692	8,031,798		8,031,798	(896,980)	7,134,818			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 of Elgin

0040006

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	(3,456)	2		4
5	Telephone, TV & Radio in Resident Rooms	(177)	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	(29,392)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(461)	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	(2,103)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,236)	20		28
29	Other-Attach Schedule Marketing Salary	(63,989)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (106,814)		\$	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)	(790,166)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (790,166)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (896,980)		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 of Elgin

ID# 0040006

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (63,989)	21
2			
3			
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49	Total	(63,989)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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)	
	A. General Services													
1	Dietary	0	0	725	0	0	0	0	0	0	0	0	725	1
2	Food Purchase	(3,917)	0	0	0	0	0	0	0	0	0	0	(3,917)	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	(89,423)	40,966	0	0	0	0	0	0	0	0	(48,457)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,917)	(89,423)	41,691	0	(51,649)	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	72,004	0	0	0	0	0	0	0	0	0	72,004	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	72,004	0	0	0	0	0	0	0	0	0	72,004	16
	C. General Administration													
17	Administrative	0	(603,147)	163,184	0	0	0	0	0	0	0	0	(439,963)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	56,593	0	0	0	0	0	0	0	0	56,593	19
20	Fees, Subscriptions & Promotions	(9,339)	0	1,579	0	0	0	0	0	0	0	0	(7,760)	20
21	Clerical & General Office Expenses	(64,166)	0	254,500	0	0	0	0	0	0	0	0	190,334	21
22	Employee Benefits & Payroll Taxes	0	0	33,574	0	0	0	0	0	0	0	0	33,574	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	18,194	0	0	0	0	0	0	0	0	18,194	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	10,502	0	0	0	0	0	0	0	0	16,293	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(73,505)	(597,356)	538,126	0	(132,735)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,422)	(614,775)	579,817	0	(112,380)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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	146,349	13,663	0	0	0	0	0	0	0	0	160,012	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,392)	532,793	0	0	0	0	0	0	0	0	0	503,401	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,532,378)	13,810	0	0	0	0	0	0	0	0	(1,518,568)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	70,555	0	0	0	0	0	0	0	0	0	70,555	36
37	TOTAL Ownership	(29,392)	(782,681)	27,473	0	(784,600)	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)	(106,814)	(1,397,456)	607,290	0	(896,980)	45							

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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	\$ 502,286	HSM Management Services, Inc.	0.00%	\$	\$ (502,286)	1
2	V	17 Administrative Fee	100,861	Midwest Administrative Services, Inc.	0.00%		(100,861)	2
3	V							3
4	V	10a Therapy	459,817	Rosewood Therapy Services, Inc.	0.00%	531,821	72,004	4
5	V							5
6	V	34 Rent	1,532,378	Elgin Real Estate, Inc.	0.00%		(1,532,378)	6
7	V	30 Depreciation		Elgin Real Estate, Inc.	0.00%	146,131	146,131	7
8	V	32 Interest		Elgin Real Estate, Inc.	0.00%	532,793	532,793	8
9	V	36 Mortgage Insurance		Elgin Real Estate, Inc.	0.00%	70,555	70,555	9
10	V	26 Property Insurance		Elgin Real Estate, Inc.	0.00%	5,791	5,791	10
11	V							11
12	V	6 Repairs & Maintenance	100,019	Senior Living Services	0.00%	10,596	(89,423)	12
13	V	30 Depreciation		Senior Living Services	0.00%	218	218	13
14	Total		\$ 2,695,361			\$ 1,297,905	\$ * (1,397,456)	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 of Elgin # 0040006 Report Period Beginning: 7/1/2005 Ending: 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%	\$ 129,324	\$ 129,324	15	
16	V	21	See Schedule VIII		HSM Management Services, Inc.	0.00%	220,428	220,428	16	
17	V	22	See Schedule VIII		HSM Management Services, Inc.	0.00%	29,047	29,047	17	
18	V	25	See Schedule VIII		HSM Management Services, Inc.	0.00%	16,653	16,653	18	
19	V	30	See Schedule VIII		HSM Management Services, Inc.	0.00%	11,154	11,154	19	
20	V	34	See Schedule VIII		HSM Management Services, Inc.	0.00%	13,238	13,238	20	
21	V	19	See Schedule VIII		HSM Management Services, Inc.	0.00%	39,113	39,113	21	
22	V	26	See Schedule VIII		HSM Management Services, Inc.	0.00%	8,396	8,396	22	
23	V	6	See Schedule VIII		HSM Management Services, Inc.	0.00%	40,027	40,027	23	
24	V	20	See Schedule VIII		HSM Management Services, Inc.	0.00%	1,146	1,146	24	
25	V								25	
26	V	1	See Schedule VIII		Midwest Administrative Services	0.00%	725	725	26	
27	V	6	See Schedule VIII		Midwest Administrative Services	0.00%	939	939	27	
28	V	17	See Schedule VIII		Midwest Administrative Services	0.00%	33,860	33,860	28	
29	V	19	See Schedule VIII		Midwest Administrative Services	0.00%	17,480	17,480	29	
30	V	20	See Schedule VIII		Midwest Administrative Services	0.00%	433	433	30	
31	V	21	See Schedule VIII		Midwest Administrative Services	0.00%	34,072	34,072	31	
32	V	22	See Schedule VIII		Midwest Administrative Services	0.00%	4,527	4,527	32	
33	V	25	See Schedule VIII		Midwest Administrative Services	0.00%	1,541	1,541	33	
34	V	26	See Schedule VIII		Midwest Administrative Services	0.00%	2,106	2,106	34	
35	V	30	See Schedule VIII		Midwest Administrative Services	0.00%	2,509	2,509	35	
36	V	34	See Schedule VIII		Midwest Administrative Services	0.00%	572	572	36	
37	V								37	
38	V								38	
39	Total			\$			\$ 607,290	\$ * 607,290	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 of Elgin # 0040006 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%	1,029,568	3	7.24%	Salary	\$ 80,345	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	450,850	3	7.24%	Salary	35,183	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	\$ 115,528		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 of Elgin

0040006

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	\$ 6,169,942	\$ 81,668	1
2	21	Salaries - Others	Total Cost	85,233,641	18	2,665,906	6,169,942	192,981	2
3	22	Payroll Taxes	Total Cost	85,233,641	18	251,062	6,169,942	18,174	3
4	22	Employee Benefits	Total Cost	85,233,641	18	102,624	6,169,942	7,429	4
5	25	Travel	Total Cost	85,233,641	18	230,054	6,169,942	16,653	5
6	30	Depreciation	Total Cost	85,233,641	18	154,087	6,169,942	11,154	6
7	34	Building Rent	Total Cost	85,233,641	18	182,875	6,169,942	13,238	7
8	19	Professional Services	Total Cost	85,233,641	18	540,314	6,169,942	39,113	8
9	21	Telephone	Total Cost	85,233,641	18	175,406	6,169,942	12,697	9
10	26	Insurance	Total Cost	85,233,641	18	115,979	6,169,942	8,396	10
11	21	Taxes, License, & Ofc Sup	Total Cost	85,233,641	18	203,759	6,169,942	14,750	11
12	6	Maintenance	Total Cost	85,233,641	18	100,147	6,169,942	7,249	12
13	20	Dues & Subscriptions	Total Cost	85,233,641	18	15,838	6,169,942	1,146	13
14	17	Direct - Admin	Direct Cost	1	1	47,656	47,656	1	47,656
15	17	Direct - Admin	Direct Cost	17	17	866,025	866,025	0	0
16	22	Direct - Payroll Taxes	Direct Cost	1	1	3,444	1	3,444	16
17	22	Direct - Payroll Taxes	Direct Cost	17	17	63,501	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	32,778	1	32,778	22
23	6	Direct - Maintenance	Direct Cost	17	17	304,811	0	0	23
24									24
25	TOTALS					\$ 7,185,274	\$ 4,707,782	\$ 508,526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost	18	\$ 10,015	\$ 10,015	6,169,942	\$ 725	1
2	6	Maintenance	Total Cost	18	11,176		6,169,942	809	2
3	17	Salaries - Officers	Total Cost	18	467,751	467,751	6,169,942	33,860	3
4	19	Professional Services	Total Cost	18	241,473		6,169,942	17,480	4
5	20	Dues & Subscriptions	Total Cost	18	5,983		6,169,942	433	5
6	21	Salaries - Other	Total Cost	18	400,855	400,855	6,169,942	29,017	6
7	21	Clerical & Office Supplies	Total Cost	18	69,834		6,169,942	5,055	7
8	22	Payroll Taxes & Emp Ben.	Total Cost	18	62,532		6,169,942	4,527	8
9	25	Travel	Total Cost	18	21,283		6,169,942	1,541	9
10	26	Insurance	Total Cost	18	29,099		6,169,942	2,106	10
11	30	Depreciation	Total Cost	18	30,041		6,169,942	2,175	11
12	34	Building Rent	Total Cost	18	7,908		6,169,942	572	12
13	17	Direct - Admin	Direct Cost	1			1		13
14	17	Direct - Admin	Direct Cost	2	21,416	21,416			14
15	30	Direct - Depreciation	Direct Cost	1	334		1	334	15
16	30	Direct - Depreciation	Direct Cost	16	5,088				16
17	6	Direct - Maintenance	Direct Cost	1	130		1	130	17
18	6	Direct - Maintenance	Direct Cost	11	3,657				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,388,575	\$ 900,037		\$ 98,764	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	\$77,227.00	8/1/04	\$ 14,522,200	\$ 14,253,716	9/1/2039	5.42%	\$ 776,984	1								
2	Less: Related Party Interest Income Offset										(247,340)	2								
3	Less: Interest Income										(29,392)	3								
4	Amortization of Loan Fees										5,638	4								
5	Real Estate Company Interest Income										(2,489)	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$77,227.00		\$ 14,522,200	\$ 14,253,716			\$ 503,401	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 14,522,200	\$ 14,253,716			\$ 503,401	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 70,555 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.)

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 of Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040006

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>06-09-100-021</u>	<u>2355 Royal Blvd, Elgin</u>	\$ <u>117,086.18</u>	\$ <u>117,086.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>117,086.18</u>	\$ <u>117,086.18</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 of Elgin

004006 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 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>206,817</u>	<u>1993</u>	<u>\$ 590,758</u>	1
2					2
3	TOTALS	206,817		\$ 590,758	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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	139			1994	\$ 4,829,673	\$	25-40	\$ 128,067	\$ 128,067	\$ 1,494,114	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	4,792		25	192	192	2,015	9
10	Hot Water Booster			1994	661		10			661	10
11	Building Sign			1994	1,827		10			1,827	11
12	Walk-in Cooler			1994	5,231		10			5,231	12
13	Salad Prep Sink			1994	1,966		10			1,966	13
14	Exhaust Hood			1994	7,104		10			7,104	14
15	Worktable with Sink			1994	1,003		10			1,003	15
16	Pot & Pan Sink			1994	3,053		10			3,053	16
17	Signage			1994	5,796		10			5,796	17
18	Addition to Phone System			1994	3,218		10			3,218	18
19	Interior Signs			1994	7,506		10			7,506	19
20	Windowsills/Panels			1994	818		10			818	20
21	Water Heaters			1994	3,162		10			3,162	21
22	Water Heater			1994	1,283		10			1,283	22
23	Emergency Generator			1994	27,491		10			27,491	23
24	Carpet			1994	7,303		10			7,303	24
25	Wallpaper/Painting			1994	76,500		10			76,500	25
26	Telephone			1994	7,550		10			7,550	26
27	Shower Room Repairs			2002	5,600		10	560	560	2,053	27
28	Seal Parking Lot			2004	7,536		2	3,768	3,768	6,594	28
29	Sinks			2006	10,355		20	105	105	105	29
30	Console Heat Pumps			2006	6,337		10	158	158	158	30
31											31
32	Leasehold Improvements - Facility:										
33	Painting			1998	16,105	122	7	122		16,105	33
34	Door Repairs			1998	4,778	171	7	171		4,778	34
35	Continued on Additional Page										
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 of Elgin

0040006

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	Mini Blinds/Wallcovering/Wallpaper	1999	\$ 6,187	\$ 785	7	\$ 785	\$	\$ 6,187	37
38	Carpeting	1999	10,413	1,486	7	1,486		10,321	38
39	Drapes	2000	10,234	1,462	7	1,462		9,138	39
40	Computer Cabling	2000	2,392	342	7	342		1,908	40
41	Carpet	2003	3,450	493	7	493		1,561	41
42	Painting/Wallcovering	2003	4,295	614	7	614		1,943	42
43	Flooring	2004	7,994	1,142	7	1,142		3,048	43
44	Patching and Replacing Wallcovering	2005	5,000	714	7	714		892	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)		\$ 5,096,613	\$ 7,331		\$ 140,181	\$ 132,850	\$ 1,722,392	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 of Elgin # 0040006 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	\$ 108,564	\$ 342	\$ 16,561	\$ 16,219	5-10 Yrs	\$ 53,791	71
72	Current Year Purchases	62,376		4,317	4,317	5-10 Yrs	4,317	72
73	Fully Depreciated Assets	577,693					577,693	73
74								74
75	TOTALS	\$ 748,633	\$ 342	\$ 20,878	\$ 20,536		\$ 635,801	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	\$	\$	\$ 5,474	\$ 5,474	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	17,074		934	934	4 Yrs	934	77
78	Senior Living Services	Various	2006	3,491		218	218	4 Yrs	218	78
79										79
80	TOTALS			\$ 20,565	\$	\$ 6,626	\$ 6,626		\$ 1,152	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)		\$ 6,456,569	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 7,673	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 167,685	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 160,012	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,359,345	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 of Elgin # 0040006 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006 Report Period Beginning:7/1/2005 Ending:6/30/2006

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	\$	15,900	\$ 202,485	\$	15,900	\$ 202,485	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,933	66,112		1,933	66,112	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		19,809	263,224	490	19,809	263,714	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				234,166		234,166	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				44,447	30,380		74,827	13
14	TOTAL			\$	37,642	\$ 576,268	\$ 265,036	37,642	\$ 841,304	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 of Elgin# 0040006Report 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (530,045)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,000</u>)	1,364,469		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,926		6
7	Other Prepaid Expenses	5,645		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 854,995	\$	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	73,245		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(57,936)		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)	\$ 15,309	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 870,304	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 130,525	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,746		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,302		31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,257		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	131,600		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 647,430	\$	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)	\$ 647,430	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 222,874	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 870,304	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 122,072	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 122,072	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	240,102	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	(139,300)	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)	\$ 100,802	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)	\$ 222,874	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 7/1/2005 Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,644,989	1
2	Discounts and Allowances for all Levels	(2,034,559)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,610,430	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,753,005	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,753,005	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	2,400	13
14	Non-Patient Meals	3,456	14
15	Telephone, Television and Radio	177	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)	\$ 6,033	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29,392	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,392	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,340	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,340	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,400,200	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,129,975	31
32	Health Care	3,461,837	32
33	General Administration	1,379,940	33
B. Capital Expense			
34	Ownership	1,674,950	34
C. Ancillary Expense			
35	Special Cost Centers	308,993	35
36	Provider Participation Fee	76,103	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,031,798	40
41	Income before Income Taxes (line 30 minus line 40)**	368,402	41
42	Income Taxes	(128,300)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 240,102	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 of Elgin

0040006

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	1,410	1,487	\$ 48,746	\$ 32.78	1
2	Assistant Director of Nursing	1,650	1,740	52,076	29.93	2
3	Registered Nurses	27,666	29,172	805,769	27.62	3
4	Licensed Practical Nurses	20,190	21,290	474,576	22.29	4
5	CNAs & Orderlies	77,243	81,450	994,769	12.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,616	5,922	96,572	16.31	8
9	Activity Director					9
10	Activity Assistants	5,121	5,400	58,506	10.83	10
11	Social Service Workers	4,122	4,346	64,516	14.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,797	22,985	214,713	9.34	15
16	Dishwashers					16
17	Maintenance Workers	2,113	2,229	25,477	11.43	17
18	Housekeepers	16,042	16,916	155,014	9.16	18
19	Laundry	4,317	4,552	36,239	7.96	19
20	Administrator	472	498	14,831	29.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,245	12,912	165,528	12.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,163	5,445	101,589	18.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	205,167	216,344	\$ 3,308,921 *	\$ 15.29	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	425	\$ 10,596	1-3	35
36	Medical Director	Contract	3,230	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	75	1,536	11-3	44
45	Social Service Consultant	145	2,584	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	645	\$ 17,946		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	859	\$ 40,375	10-3	50
51	Licensed Practical Nurses	393	14,694	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,252	\$ 55,069		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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 grouped on Line 17, Col. 1:				Workers' Compensation Insurance	\$ 86,638	IDPH License Fee	\$ 995	
Peggy Aschenbrenner	Administrator	0.00%	14,831	Unemployment Compensation Insurance	64,978	Advertising: Employee Recruitment	25,299	
Total Direct Administrator Cost from HSM Mgmt - Line 17, Col 7:				FICA Taxes	250,665	Health Care Worker Background Check		
Peggy Aschenbrenner	Administrator	0.00%	47,656	Employee Health Insurance	3,683	(Indicate # of checks performed <u>110</u>)	1,100	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Meals		Patient Background Checks	<u>20</u> 200	
(List each licensed administrator separately.)				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	6,339	
			\$ 62,487	Tuition Reimbursement	2,166	Misc. Dues/Subscriptions	8,290	
B. Administrative - Other				Employee Uniforms	518	Related Party Allocations	1,579	
			Amount	Employee Relations	4,149			
Management Fees			\$ 502,286	Employee Physicals	999	Less: Public Relations Expense	()	
Administrative Fees			100,861	Recruitment Fees	750	Non-allowable advertising	(2,103)	
TOTAL (agree to Schedule V, line 17, col. 3)				Related Party Allocations	33,574	Yellow page advertising	(4,236)	
			\$ 603,147	TOTAL (agree to Schedule V, line 22, col.8)			\$ 448,120	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
C.J. Schlosser & Company	Accountant/Consultant	\$ 8,220		Section Not Applicable		Out-of-State Travel	\$	
	Professional Fees	50						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			In-State Travel	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,270	\$				
							Seminar Expense	1,762
							Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,762

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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													
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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 - \$7,673
- (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. \$ 77,449 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. \$ 76,103
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. \$ 3,456
- (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 ELGIN
RECLASSIFICATIONS
MEDICAID COST REPORT
6/30/06

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(995)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	995	20

ROSEWOOD CARE CENTER OF ELGIN
IDPH ID #0040006
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 ALTON	EAST ALTON, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
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.
ELGIN 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.

ROSEWOOD CARE CENTER OF ELGIN
IDPH ID #0040006
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 4,001</u>
	<u>\$ 4,001</u>

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