

		FOR BHF USE					

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

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

I. IDPH Facility ID Number: 0036152

Facility Name: Rosewood Care Center of Moline

Address: 7300 34th Avenue Moline 61265
 Number City Zip Code

County: Rock Island

Telephone Number: (309) 792-5940 Fax # ()

HFS ID Number: 431453169001

Date of Initial License for Current Owners: 5/6/1990

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

(Signed) _____ (Date) _____

Officer or Administrator of Provider
 (Type or Print Name) _____
 (Title) _____

(Signed) Accountant's Compilation Report Attached (Date) _____

Paid Preparer
 (Print Name and Title) Cindy A. Tefteller
 (Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
 (Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline

0036152 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</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>120</u>	TOTALS	<u>120</u>	<u>43,800</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>13,025</u>	<u>13,025</u>	8
9	SNF/PED					9
10	ICF	<u>4,226</u>	<u>14,984</u>		<u>19,210</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,226</u>	<u>14,984</u>	<u>13,025</u>	<u>32,235</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.60%

D. How many bed-hold days during this year were paid by the Department? 11 (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 5/7/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/7/1990 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 68 and days of care provided 13,025

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 of Moline # 0036152 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	185,432	19,356	10,863	215,651		215,651	574	216,225			1
2	Food Purchase		153,961		153,961		153,961	(10,175)	143,786			2
3	Housekeeping	125,983	27,028		153,011		153,011		153,011			3
4	Laundry	38,541	13,070		51,611		51,611		51,611			4
5	Heat and Other Utilities			124,949	124,949		124,949		124,949			5
6	Maintenance	26,440	4,840	102,437	133,717		133,717	8,291	142,008			6
7	Other (specify):* Sanitation			11,826	11,826		11,826		11,826			7
8	TOTAL General Services	376,396	218,255	250,075	844,726		844,726	(1,310)	843,416			8
	B. Health Care and Programs											
9	Medical Director			20,388	20,388		20,388		20,388			9
10	Nursing and Medical Records	1,731,664	158,525	21,146	1,911,335		1,911,335		1,911,335			10
10a	Therapy	66,966	4,157	775,398	846,521		846,521	(92,437)	754,084			10a
11	Activities	48,679	3,272	1,656	53,607		53,607		53,607			11
12	Social Services	41,843		1,656	43,499		43,499		43,499			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,889,152	165,954	820,244	2,875,350		2,875,350	(92,437)	2,782,913			16
	C. General Administration											
17	Administrative			811,200	811,200		811,200	(653,301)	157,899			17
18	Directors Fees											18
19	Professional Services			8,270	8,270		8,270	44,776	53,046			19
20	Dues, Fees, Subscriptions & Promotions			30,271	30,271		30,271	(8,616)	21,655			20
21	Clerical & General Office Expenses	134,388	30,601	8,592	173,581		173,581	135,889	309,470			21
22	Employee Benefits & Payroll Taxes			312,713	312,713		312,713	28,645	341,358			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,184	1,184		1,184	(19)	1,165			24
25	Other Admin. Staff Transportation			9,737	9,737		9,737	14,482	24,219			25
26	Insurance-Prop.Liab.Malpractice			63,122	63,122		63,122	14,101	77,223			26
27	Other (specify):*											27
28	TOTAL General Administration	134,388	30,601	1,245,089	1,410,078		1,410,078	(424,043)	986,035			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,399,936	414,810	2,315,408	5,130,154		5,130,154	(517,790)	4,612,364			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 of Moline #0036152 Report Period Beginning: 7/1/05 Ending: 6/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			14,065	14,065		14,065	113,151	127,216		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							438,056	438,056		32
33	Real Estate Taxes			124,894	124,894		124,894		124,894		33
34	Rent-Facility & Grounds			1,346,385	1,346,385		1,346,385	(1,335,458)	10,927		34
35	Rent-Equipment & Vehicles			18,682	18,682		18,682		18,682		35
36	Other (specify):* Mortgage Insur.							192,163	192,163		36
37	TOTAL Ownership			1,504,026	1,504,026		1,504,026	(592,088)	911,938		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		251,088	56,351	307,439		307,439		307,439		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			65,700	65,700		65,700		65,700		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		251,088	122,051	373,139		373,139		373,139		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,399,936	665,898	3,941,485	7,007,319		7,007,319	(1,109,878)	5,897,441		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 Moline

0036152

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	(9,821)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,469)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(354)	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)	24		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	(2,178)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,688)	20		28
29	Other-Attach Schedule Marketing Salary	(65,475)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,004)		\$	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)	(1,010,874)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,010,874)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,109,878)		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 Moline

ID# 0036152

Report Period Beginning: 7/1/05

Ending: 6/30/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (65,475)	21
2			
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49	Total	(65,475)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Moline

0036152

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	574	0	0	0	0	0	0	0	0	574	1
2	Food Purchase	(10,175)	0	0	0	0	0	0	0	0	0	0	(10,175)	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	(21,551)	29,842	0	0	0	0	0	0	0	0	8,291	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,175)	(21,551)	30,416	0	(1,310)	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	(92,437)	0	0	0	0	0	0	0	0	0	(92,437)	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	(92,437)	0	0	0	0	0	0	0	0	0	(92,437)	16
	C. General Administration													
17	Administrative	0	(811,200)	157,899	0	0	0	0	0	0	0	0	(653,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	44,776	0	0	0	0	0	0	0	0	44,776	19
20	Fees, Subscriptions & Promotions	(9,866)	0	1,250	0	0	0	0	0	0	0	0	(8,616)	20
21	Clerical & General Office Expenses	(65,475)	0	201,364	0	0	0	0	0	0	0	0	135,889	21
22	Employee Benefits & Payroll Taxes	0	0	28,645	0	0	0	0	0	0	0	0	28,645	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(19)	0	0	0	0	0	0	0	0	0	0	(19)	24
25	Other Admin. Staff Transportation	0	0	14,482	0	0	0	0	0	0	0	0	14,482	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	8,310	0	0	0	0	0	0	0	0	14,101	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,360)	(805,409)	456,726	0	(424,043)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,535)	(919,397)	487,142	0	(517,790)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 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	102,341	10,810	0	0	0	0	0	0	0	0	113,151	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,469)	451,525	0	0	0	0	0	0	0	0	0	438,056	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,346,385)	10,927	0	0	0	0	0	0	0	0	(1,335,458)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	192,163	0	0	0	0	0	0	0	0	0	192,163	36
37	TOTAL Ownership	(13,469)	(600,356)	21,737	0	(592,088)	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)	(99,004)	(1,519,753)	508,879	0	(1,109,878)	45							

Facility Name & ID Number Rosewood Care Center of Moline

0036152

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fee	\$ 712,550	HSM Management	0.00%	\$	\$ (712,550)	1
2	V	17 Administrative Fee	98,650	Midwest Administrative Services, Inc.	0.00%		(98,650)	2
3	V							3
4	V	10a Therapy	775,398	Rosewood Therapy Company, Inc.	0.00%	682,961	(92,437)	4
5	V							5
6	V	34 Rent	1,346,385	Moline Real Estate, Inc.	0.00%		(1,346,385)	6
7	V	30 Depreciation		Moline Real Estate, Inc.	0.00%	102,168	102,168	7
8	V	32 Interest		Moline Real Estate, Inc.	0.00%	451,525	451,525	8
9	V	26 Property Insurance		Moline Real Estate, Inc.	0.00%	5,791	5,791	9
10	V	36 Mortgage Insurance		Moline Real Estate, Inc.	0.00%	192,163	192,163	10
11	V							11
12	V	6 Repairs & Maintenance	29,322	Senior Living Services, Inc.	0.00%	7,771	(21,551)	12
13	V	30 Depreciation		Senior Living Services, Inc.	0.00%	173	173	13
14	Total		\$ 2,962,305			\$ 1,442,552	\$ * (1,519,753)	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 Moline# 0036152Report 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%	\$ 131,109	\$ 131,109	15		
16	V	21	See Schedule VIII		HSM Management Services, Inc.	0.00%	174,405	174,405	16		
17	V	22	See Schedule VIII		HSM Management Services, Inc.	0.00%	25,063	25,063	17		
18	V	25	See Schedule VIII		HSM Management Services, Inc.	0.00%	13,263	13,263	18		
19	V	30	See Schedule VIII		HSM Management Services, Inc.	0.00%	8,825	8,825	19		
20	V	34	See Schedule VIII		HSM Management Services, Inc.	0.00%	10,474	10,474	20		
21	V	19	See Schedule VIII		HSM Management Services, Inc.	0.00%	30,946	30,946	21		
22	V	26	See Schedule VIII		HSM Management Services, Inc.	0.00%	6,643	6,643	22		
23	V	6	See Schedule VIII		HSM Management Services, Inc.	0.00%	29,202	29,202	23		
24	V	20	See Schedule VIII		HSM Management Services, Inc.	0.00%	907	907	24		
25	V								25		
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	574	574	26		
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	640	640	27		
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	26,790	26,790	28		
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	13,830	13,830	29		
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	343	343	30		
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	26,959	26,959	31		
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	3,582	3,582	32		
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,219	1,219	33		
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,667	1,667	34		
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,985	1,985	35		
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	453	453	36		
37	V								37		
38	V								38		
39	Total			\$			\$ 508,879	\$ * 508,879	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 Moline # 0036152 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%	1,046,343	2	5.73%	Salary	\$ 63,570	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	458,196	2	5.73%	Salary	27,837	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	\$ 91,407		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 Moline

0036152

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	\$ 4,881,738	\$ 64,617	1	
2	21	Salaries - Others	Total Cost	85,233,641	18	2,665,906	4,881,738	152,689	2	
3	22	Payroll Taxes	Total Cost	85,233,641	18	251,062	4,881,738	14,380	3	
4	22	Employee Benefits	Total Cost	85,233,641	18	102,624	4,881,738	5,878	4	
5	25	Travel	Total Cost	85,233,641	18	230,054	4,881,738	13,176	5	
6	30	Depreciation	Total Cost	85,233,641	18	154,087	4,881,738	8,825	6	
7	34	Building Rent	Total Cost	85,233,641	18	182,875	4,881,738	10,474	7	
8	19	Professional Services	Total Cost	85,233,641	18	540,314	4,881,738	30,946	8	
9	21	Telephone	Total Cost	85,233,641	18	175,406	4,881,738	10,046	9	
10	26	Insurance	Total Cost	85,233,641	18	115,979	4,881,738	6,643	10	
11	21	Taxes, License, & Office Sup.	Total Cost	85,233,641	18	203,759	4,881,738	11,670	11	
12	6	Maintenance	Total Cost	85,233,641	18	100,147	4,881,738	5,736	12	
13	20	Dues & Subscriptions	Total Cost	85,233,641	18	15,838	4,881,738	907	13	
14	17	Direct - Admin	Direct Cost	1	1	66,492	66,492	1	66,492	14
15	17	Direct - Admin	Direct Cost	17	17	847,189	847,189	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	4,805	1	4,805	16	
17	22	Direct - Payroll Taxes	Direct Cost	17	17	62,140	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	87	1	87	20	
21	25	Direct - Travel	Direct Cost	17	17	151	0	0	21	
22	6	Direct - Maintenance	Direct Cost	1	1	23,466	1	23,466	22	
23	6	Direct - Maintenance	Direct Cost	17	17	314,123	0	0	23	
24									24	
25	TOTALS					\$ 7,185,274	\$ 4,707,782	\$ 430,837	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline

0036152

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	\$ 4,881,738	\$ 574	1
2	6	Maintenance	Total Cost	85,233,641	18	11,176	4,881,738	640	2
3	17	Salaries - Officers	Total Cost	85,233,641	18	467,751	4,881,738	26,790	3
4	19	Professional Services	Total Cost	85,233,641	18	241,473	4,881,738	13,830	4
5	20	Dues & Subscriptions	Total Cost	85,233,641	18	5,983	4,881,738	343	5
6	21	Salaries - Other	Total Cost	85,233,641	18	400,855	4,881,738	22,959	6
7	21	Clerical & Office Supplies	Total Cost	85,233,641	18	69,834	4,881,738	4,000	7
8	22	Payroll Taxes & Empl. Benefits	Total Cost	85,233,641	18	62,532	4,881,738	3,582	8
9	25	Travel	Total Cost	85,233,641	18	21,283	4,881,738	1,219	9
10	26	Insurance	Total Cost	85,233,641	18	29,099	4,881,738	1,667	10
11	30	Depreciation	Total Cost	85,233,641	18	30,041	4,881,738	1,721	11
12	34	Building Rent	Total Cost	85,233,641	18	7,908	4,881,738	453	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	264	1	264	15
16	30	Direct - Depreciation	Direct Cost	17	17	5,158			16
17	6	Direct - Maintenance	Direct Cost	1	1		1		17
18	6	Direct - Maintenance	Direct Cost	17	17	3,787			18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,388,575	\$ 900,037	\$ 78,042	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	Mortgage Refinancing	\$66,689.00	11/1/05	\$ 13,554,600	\$ 13,466,249	12/1/40	4.80%	\$ 405,212	1								
2	Bank of America, N.A.		X	Mortgage	Varies	12/8/04	13,400,000	0	1/2/08	Prime	256,525	2								
3	Amortization of Loan Fees										53,013	3								
4	Less: Related Party Interest										(262,918)	4								
5	Interest Income Offset										(13,469)	5								
Working Capital																				
6	Less: Real Estate Company Interest Income										(307)	6								
7												7								
8												8								
9	TOTAL Facility Related				\$66,689.00		\$ 26,954,600	\$ 13,466,249			\$ 438,056	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 26,954,600	\$ 13,466,249			\$ 438,056	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 192,163 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 Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0036152

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>07-649-95-00</u>	<u>7300 34 Avenue, Parcel # 13991</u>	\$ <u>105,713.24</u>	\$ <u>105,713.24</u>
2. <u>07-649-94-00</u>	<u>Parcel number 13990</u>	\$ <u>11,292.44</u>	\$ <u>11,292.44</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>117,005.68</u>	\$ <u>117,005.68</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 Moline

0036152 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 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>4.4 acres</u>	<u>1989</u>	<u>\$ 210,330</u>	1
2					2
3	TOTALS	4.4 acres		\$ 210,330	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline

0036152

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	120			1990	\$ 2,845,310	\$	40	\$ 71,133	\$ 71,133	\$ 1,149,982	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Site Improvements		1990	277,100		20-25	11,096	11,096	179,396	9
10		Curbing		1991	2,743		25	110	110	1,649	10
11		Landscaping		1991	4,560		25	182	182	2,716	11
12		Irrigation System		1993	10,257		25	410	410	5,297	12
13		Water Meter & Back		1993	1,803		25	72	72	924	13
14		Walk-In Cooler		1990	7,845		20	392	392	6,337	14
15		Sinks		1990	6,386		10-20	62	62	6,153	15
16		Exhaust Hood w/ Fire Extinguisher		1990	6,317		10			6,317	16
17		Generator		1990	15,779		20	789	789	12,755	17
18		Signage		1990	2,721		15			2,721	18
19		Facility Signs		1990	1,757		10			1,757	19
20		Cubicle Curtain Track		1990	6,176		10			6,176	20
21		Fire Alarm System		1990	99,726		10			99,726	21
22		Hot Water Heater		1990	6,706		10			6,706	22
23		Water Heater Tank		1990	7,961		10			7,961	23
24		Wallcovering		1990	24,650		10			24,650	24
25		Carpeting		1990	8,025		10			8,025	25
26		Steel Trash Doors		1991	1,825		10			1,825	26
27		Parking Lot Addition		2000	11,485		25	460	460	2,604	27
28		Seal & Re-stripe Parking Lot		2003	4,530		25	181	181	498	28
29		Shingle Roof Replacement		2005	24,958		10	2,495	2,495	3,743	29
30		Parking Lot Improvements		2005	16,350		8	1,703	1,703	1,703	30
31		Console Heat Pumps		2006	6,337		10	159	159	159	31
32		Backflow Preventer		2005	6,285		20	183	183	183	32
33		Door Closers		2006	2,603		15	87	87	87	33
34											34
35											35
36		Continued on page 12A									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 Moline**

0036152

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Leasehold Improvements - Facility:		\$	\$		\$	\$	\$	37
38	Painting / Floor Stripping	1995	9,426		7			9,426	38
39	Carpeting	1995	292		7			292	39
40	Carpeting	1996	14,000		7			14,000	40
41	Cabinet Work	1996	1,868		7			1,868	41
42	Base Stripping	1996	1,509		7			1,509	42
43	Painting	1996	19,996		7			19,996	43
44	Wallcovering / Bathroom Mirrors / Plants	1999	11,651	1,132	7	1,132		11,651	44
45	Draperies / Office Space / Counter	1999	2,256	102	7	102		2,256	45
46	Wallcovering	1999	15,783	2,255	7	2,255		15,357	46
47	Carpeting	2000	4,718	674	7	674		4,151	47
48	Flooring	2000	2,371	339	7	339		1,891	48
49	Countertops	2000	3,894	556	7	556		3,106	49
50	Paneling	2000	1,270	181	7	181		1,013	50
51	Room Signs	2000	1,082	155	7	155		863	51
52	Sink	2000	1,935	276	7	276		1,543	52
53	Computer Cabling	2000	2,895	414	7	414		2,275	53
54	Flooring	2000	5,028	718	7	718		3,830	54
55	Wallpaper	2001	15,605	2,229	7	2,229		11,331	55
56	Wallcovering	2002	648	93	7	93		395	56
57	Repave Parking Lot	2002	11,830	1,690	7	1,690		7,323	57
58	Wallpaper	2004	12,185	1,741	7	1,741		3,627	58
59	Carpeting	2004	3,830	547	7	547		866	59
60	Patching, Sealing & Striping Parking Lot	2005	2,900	276	7	276		276	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)		\$ 3,557,167	\$ 13,378		\$ 102,892	\$ 89,514	\$ 1,658,895	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 Moline # 0036152 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	\$ 162,608	\$ 687	\$ 17,657	\$ 16,970	5-10 Yrs	\$ 106,616	71
72	Current Year Purchases	46,549		1,424	1,424	5-10 Yrs	1,424	72
73	Fully Depreciated Assets	420,211					420,211	73
74								74
75	TOTALS	\$ 629,368	\$ 687	\$ 19,081	\$ 18,394		\$ 528,251	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$	\$	\$ 4,331	\$ 4,331	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	13,509		739	739	4 Yrs	739	77
78	Senior Living Services	Various	2006	2,762		173	173	4 Yrs	173	78
79										79
80	TOTALS			\$ 16,271	\$	\$ 5,243	\$ 5,243		\$ 912	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 4,413,136	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 14,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 127,216	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 113,151	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,188,058	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.

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	\$	31,289	\$ 324,154	\$	31,289	\$ 324,154	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		3,457	59,524		3,457	59,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		28,643	299,283	4,157	28,643	303,440	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				233,776		233,776	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				56,351	17,312		73,663	13
14	TOTAL			\$	63,389	\$ 739,312	\$ 255,245	63,389	\$ 994,557	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 Moline # 0036152 Report 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	\$ (60,119)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>55,000</u>)	857,854		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,826		6
7	Other Prepaid Expenses	3,146		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposit</u>	2,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 814,707	\$	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	151,781		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(121,829)		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)	\$ 29,952	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 844,659	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 157,939	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,743		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,125		31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,427		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	159,100		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 662,334	\$	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)	\$ 662,334	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 182,325	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 844,659	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 149,344	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 149,344	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	302,081	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	(269,100)	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)	\$ 32,981	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)	\$ 182,325	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline# 0036152Report Period Beginning: 7/1/05Ending: 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	\$ 7,762,639	1
2	Discounts and Allowances for all Levels	(3,221,026)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,541,613	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,891,688	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,891,688	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,600	13
14	Non-Patient Meals	9,821	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,421	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,469	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	509	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 509	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,460,700	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	844,726	31
32	Health Care	2,875,350	32
33	General Administration	1,410,078	33
B. Capital Expense			
34	Ownership	1,504,026	34
C. Ancillary Expense			
35	Special Cost Centers	307,439	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,007,319	40
41	Income before Income Taxes (line 30 minus line 40)**	453,381	41
42	Income Taxes	(151,300)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 302,081	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 Moline

0036152

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	2,088	2,199	\$ 63,087	\$ 28.69	1
2	Assistant Director of Nursing	2,113	2,225	53,510	24.05	2
3	Registered Nurses	11,905	12,534	259,773	20.73	3
4	Licensed Practical Nurses	31,960	33,649	591,080	17.57	4
5	CNAs & Orderlies	66,590	70,109	691,842	9.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,543	4,783	66,966	14.00	8
9	Activity Director					9
10	Activity Assistants	5,120	5,390	48,679	9.03	10
11	Social Service Workers	4,012	4,224	41,843	9.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,413	20,439	185,432	9.07	15
16	Dishwashers					16
17	Maintenance Workers	1,874	1,973	26,440	13.40	17
18	Housekeepers	14,744	15,523	125,983	8.12	18
19	Laundry	5,078	5,346	38,541	7.21	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,044	12,680	134,388	10.60	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	5,214	5,490	72,372	13.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,698	196,564	\$ 2,399,936 *	\$ 12.21	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	470	\$ 10,863	1-3	35
36	Medical Director	Contract	20,388	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	60	1,656	11-3	44
45	Social Service Consultant	60	1,656	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	590	\$ 34,563		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	404	\$ 14,892	10-3	50
51	Licensed Practical Nurses	187	6,254	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	591	\$ 21,146		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline

Report Period Beginning: 7/1/05 Ending:

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 - \$6,624
- (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. \$ 45,404 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 9,821
- (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 MOLINE, INC.
IDPH ID #0036152
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 9,737</u>
	<u><u>\$ 9,737</u></u>

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

ROSEWOOD CARE CENTER OF MOLINE, INC.
IDPH ID #0036152
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 INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, 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.
MOLINE 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