

		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:** 0035352

**Facility Name:** Rosewood Care Center of Peoria

**Address:** 1500 West Northmoor Road Peoria 61614  
 Number City Zip Code

**County:** Peoria

**Telephone Number:** (309) 637-2000 Fax # ( )

**HFS ID Number:** 431446786001

**Date of Initial License for Current Owners:** 6/12/1989

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

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

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

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) \_\_\_\_\_

(Title) \_\_\_\_\_

**Paid Preparer**

(Signed) Accountant's Compilation Report Attached (Date) \_\_\_\_\_

(Print Name and Title) Cindy A. Tefteller

(Firm Name & Address) C.J. Schlosser & Company  
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

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352 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>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>10,206</u>	<u>10,206</u>	8
9	SNF/PED					9
10	ICF	<u>2,931</u>	<u>17,758</u>		<u>20,689</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,931</u>	<u>17,758</u>	<u>10,206</u>	<u>30,895</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.54%

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

270 (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 &amp; 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 6/12/1989

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

YES  Date 6/12/1989 NO 

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

YES  NO  If YES, enter number of beds certified 58 and days of care provided 10,206Medicare 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 Peoria # 0035352 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	199,700	20,074	8,095	227,869		227,869	569	228,438		1
2	Food Purchase		144,786		144,786		144,786	(6,354)	138,432		2
3	Housekeeping	142,827	35,076		177,903		177,903		177,903		3
4	Laundry	39,640	15,858		55,498		55,498		55,498		4
5	Heat and Other Utilities			127,373	127,373		127,373		127,373		5
6	Maintenance		11,174	76,277	87,451		87,451	32,571	120,022		6
7	Other (specify):* <b>Sanitation</b>			9,695	9,695		9,695		9,695		7
8	<b>TOTAL General Services</b>	382,167	226,968	221,440	830,575		830,575	26,786	857,361		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,470	16,470		16,470		16,470		9
10	Nursing and Medical Records	1,493,968	193,104	315,184	2,002,256		2,002,256		2,002,256		10
10a	Therapy	64,186	6,145	574,192	644,523		644,523	42,082	686,605		10a
11	Activities	56,057	4,296	308	60,661		60,661		60,661		11
12	Social Services	35,394	130	500	36,024		36,024		36,024		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,649,605	203,675	906,654	2,759,934		2,759,934	42,082	2,802,016		16
	<b>C. General Administration</b>										
17	Administrative			586,400	586,400		586,400	(454,048)	132,352		17
18	Directors Fees										18
19	Professional Services			8,270	8,270		8,270	44,422	52,692		19
20	Dues, Fees, Subscriptions & Promotions			29,481	29,481	995	30,476	(6,392)	24,084		20
21	Clerical & General Office Expenses	142,024	31,875	9,316	183,215		183,215	141,757	324,972		21
22	Employee Benefits & Payroll Taxes			289,622	289,622		289,622	26,724	316,346		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,175	2,175	(995)	1,180		1,180		24
25	Other Admin. Staff Transportation			6,033	6,033		6,033	14,281	20,314		25
26	Insurance-Prop.Liab.Malpractice			54,081	54,081		54,081	14,034	68,115		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	142,024	31,875	985,378	1,159,277		1,159,277	(219,222)	940,055		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,173,796	462,518	2,113,472	4,749,786		4,749,786	(150,354)	4,599,432		29

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

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

Facility Name & ID Number Rosewood Care Center of Peoria #0035352 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			8,160	8,160		8,160	161,940	170,100			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							572,223	572,223			32
33	Real Estate Taxes			83,079	83,079		83,079		83,079			33
34	Rent-Facility & Grounds			1,195,983	1,195,983		1,195,983	(1,185,143)	10,840			34
35	Rent-Equipment & Vehicles			36,286	36,286		36,286		36,286			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,323,508	1,323,508		1,323,508	(450,980)	872,528			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,286	40,353	259,639		259,639		259,639			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	<b>TOTAL Special Cost Centers</b>		219,286	106,053	325,339		325,339		325,339			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,173,796	681,804	3,543,033	6,398,633		6,398,633	(601,334)	5,797,299			45

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

Facility Name & ID Number Rosewood Care Center of Peoria

# 0035352

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,942)	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	(23,464)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(412)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,060)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,572)	20		28
29	Other-Attach Schedule Marketing Salary	(58,010)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (95,460)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(505,874)	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (505,874)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (601,334)</b>		<b>37</b>

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Rosewood Care Center of Peoria

ID# 0035352

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (58,010)	21
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(58,010)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rosewood Care Center of Peoria

# 0035352

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	569	0	0	0	0	0	0	0	0	569	1
2	Food Purchase	(6,354)	0	0	0	0	0	0	0	0	0	0	(6,354)	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	7,152	25,419	0	0	0	0	0	0	0	0	32,571	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,354)</b>	<b>7,152</b>	<b>25,988</b>	<b>0</b>	<b>26,786</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	42,082	0	0	0	0	0	0	0	0	0	42,082	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>42,082</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>42,082</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(586,400)	132,352	0	0	0	0	0	0	0	0	(454,048)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	44,422	0	0	0	0	0	0	0	0	44,422	19
20	Fees, Subscriptions & Promotions	(7,632)	0	1,240	0	0	0	0	0	0	0	0	(6,392)	20
21	Clerical & General Office Expenses	(58,010)	0	199,767	0	0	0	0	0	0	0	0	141,757	21
22	Employee Benefits & Payroll Taxes	0	0	26,724	0	0	0	0	0	0	0	0	26,724	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	14,281	0	0	0	0	0	0	0	0	14,281	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	8,243	0	0	0	0	0	0	0	0	14,034	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(65,642)</b>	<b>(580,609)</b>	<b>427,029</b>	<b>0</b>	<b>(219,222)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(71,996)</b>	<b>(531,375)</b>	<b>453,017</b>	<b>0</b>	<b>(150,354)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Peoria

# 0035352

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	151,161	10,779	0	0	0	0	0	0	0	0	161,940	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,464)	595,687	0	0	0	0	0	0	0	0	0	572,223	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,195,983)	10,840	0	0	0	0	0	0	0	0	(1,185,143)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(23,464)</b>	<b>(449,135)</b>	<b>21,619</b>	<b>0</b>	<b>(450,980)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(95,460)</b>	<b>(980,510)</b>	<b>474,636</b>	<b>0</b>	<b>(601,334)</b>	<b>45</b>							

Facility Name & ID Number Rosewood Care Center of Peoria

# 0035352

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 Schedule		See Attached Schedule		
Darrell Hoefling	25.00%	See Attached Schedule		See Attached Schedule		

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	\$ 498,750	HSM Management Services, Inc.	0.00%	\$	\$ (498,750)	1
2	V	17 Administrative Fee	87,650	Midwest Administrative Services, Inc.	0.00%		(87,650)	2
3	V							3
4	V	10a Therapy	574,192	Rosewood Therapy Services, Inc.	0.00%	616,274	42,082	4
5	V							5
6	V	34 Rent	1,195,983	Peoria Real Estate, Inc.	0.00%		(1,195,983)	6
7	V	30 Depreciation		Peoria Real Estate, Inc.	0.00%	150,990	150,990	7
8	V	32 Interest		Peoria Real Estate, Inc.	0.00%	595,687	595,687	8
9	V	26 Property Insurance		Peoria Real Estate, Inc.	0.00%	5,791	5,791	9
10	V							10
11	V	6 Repairs & Maintenance	1,334	Senior Living Services	0.00%	8,486	7,152	11
12	V	30 Depreciation		Senior Living Services	0.00%	171	171	12
13	V							13
14	Total		\$ 2,357,909			\$ 1,377,399	\$ * (980,510)	14

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

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352Report Period Beginning: 7/1/2005Ending: 6/30/2006

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	17	See Schedule VIII	\$	HSM Management Services, Inc.	0.00%	\$ 105,774	\$ 105,774			15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	0.00%	173,022	173,022			16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	0.00%	23,171	23,171			17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	0.00%	13,072	13,072			18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	0.00%	8,755	8,755			19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	0.00%	10,391	10,391			20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	0.00%	30,701	30,701			21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	0.00%	6,590	6,590			22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	0.00%	24,784	24,784			23
24	V	20	See Schedule VIII		HSM Management Services, Inc.	0.00%	900	900			24
25	V										25
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	569	569			26
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	635	635			27
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	26,578	26,578			28
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	13,721	13,721			29
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	340	340			30
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	26,745	26,745			31
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	3,553	3,553			32
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,209	1,209			33
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,653	1,653			34
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	2,024	2,024			35
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	449	449			36
37	V										37
38	V										38
39	Total			\$			\$ 474,636	\$ *	474,636		39

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

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 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%	1,046,847	2	5.68%	Salary	\$ 63,065	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	458,417	2	5.68%	Salary	27,617	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	\$ 90,682		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352

Report Period Beginning:

7/1/2005Ending: 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 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	85,233,641	18	\$ 1,128,195	\$ 1,128,195	4,842,992	\$ 64,104	1
2	21	Salaries - Others	Total Cost	85,233,641	18	2,665,906	2,665,906	4,842,992	151,477	2
3	22	Payroll Taxes	Total Cost	85,233,641	18	251,062		4,842,992	14,265	3
4	22	Employee Benefits	Total Cost	85,233,641	18	102,624		4,842,992	5,831	4
5	25	Travel	Total Cost	85,233,641	18	230,054		4,842,992	13,072	5
6	30	Depreciation	Total Cost	85,233,641	18	154,087		4,842,992	8,755	6
7	34	Building Rent	Total Cost	85,233,641	18	182,875		4,842,992	10,391	7
8	19	Professional Services	Total Cost	85,233,641	18	540,314		4,842,992	30,701	8
9	21	Telephone	Total Cost	85,233,641	18	175,406		4,842,992	9,967	9
10	26	Insurance	Total Cost	85,233,641	18	115,979		4,842,992	6,590	10
11	21	Taxes, Licenses, Ofc. Sup.	Total Cost	85,233,641	18	203,759		4,842,992	11,578	11
12	6	Maintenance	Total Cost	85,233,641	18	100,147		4,842,992	5,690	12
13	20	Dues & Subscriptions	Total Cost	85,233,641	18	15,838		4,842,992	900	13
14	17	Direct - Admin	Direct Cost	1	1	41,670	41,670	1	41,670	14
15	17	Direct - Admin	Direct Cost	17	17	872,011	872,011	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	3,075		1	3,075	16
17	22	Direct - Payroll Taxes	Direct Cost	17	17	63,870		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	19,094		1	19,094	22
23	6	Direct - Maintenance	Direct Cost	17	17	318,495		0	0	23
24										24
25	TOTALS					\$ 7,185,274	\$ 4,707,782		\$ 397,160	25

Facility Name & ID Number Rosewood Care Center of Peoria

# 0035352

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 85,233,641	18	\$ 10,015	\$ 10,015	4,842,992	\$ 569	1
2	6	Maintenance	Total Cost 85,233,641	18	11,176		4,842,992	635	2
3	17	Salaries - Officers	Total Cost 85,233,641	18	467,751	467,751	4,842,992	26,578	3
4	19	Professional Services	Total Cost 85,233,641	18	241,473		4,842,992	13,721	4
5	20	Dues & Subscriptions	Total Cost 85,233,641	18	5,983		4,842,992	340	5
6	21	Salaries - Others	Total Cost 85,233,641	18	400,855	400,855	4,842,992	22,777	6
7	21	Clerical & Office Supplies	Total Cost 85,233,641	18	69,834		4,842,992	3,968	7
8	22	Payroll Taxes & Emp Ben.	Total Cost 85,233,641	18	62,532		4,842,992	3,553	8
9	25	Travel	Total Cost 85,233,641	18	21,283		4,842,992	1,209	9
10	26	Insurance	Total Cost 85,233,641	18	29,099		4,842,992	1,653	10
11	30	Depreciation	Total Cost 85,233,641	18	30,041		4,842,992	1,707	11
12	34	Building Rent	Total Cost 85,233,641	18	7,908		4,842,992	449	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	317		1	317	15
16	30	Direct - Depreciation	Direct Cost 17	17	5,105				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		\$ 77,476	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		X	Refinance Mortgage	Varies	6/30/05	\$ 12,000,000	\$ 12,000,000	6/2008	LIBOR+1	\$ 838,883	1								
2	Less: Related Party Income										(243,196)	2								
3	Less: Interest Income Offset										(23,464)	3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 12,000,000	\$ 12,000,000			\$ 572,223	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$		14							
15	<b>TOTALS (line 9+line14)</b>						\$ 12,000,000	\$ 12,000,000			\$ 572,223	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	<b>74,907</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>117,151</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>42,244</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>40,835</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>83,079</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>69,725</b>	<b>8</b>
	2002	<b>72,217</b>	<b>9</b>
	2003	<b>76,975</b>	<b>10</b>
	2004	<b>74,165</b>	<b>11</b>
	2005	<b>80,068</b>	<b>12</b>

2004 Payment = \$37,083

2005 Payment = \$80,068

Accrual =1/2 of estimated 2006 tax bill (\$40,835)

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Rosewood Care Center of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0035352

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>14-17-326-009</u>	<u>1500 W. Northmoor Road</u>	\$ <u>77,931.46</u>	\$ <u>77,931.46</u>
2. <u>14-17-326-010</u>	<u>SW 1/4 Sec 17-9N-8E</u>	\$ <u>1,430.56</u>	\$ <u>1,430.56</u>
3. <u>14-17-376-001</u>	<u>SW 1/4 Sec 17-9-8E</u>	\$ <u>706.10</u>	\$ <u>706.10</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>80,068.12</u>	\$ <u>80,068.12</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 Peoria

# 0035352 Report Period Beginning:

7/1/2005 Ending:

6/30/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,500 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>7.343 Acres</u>	<u>1989</u>	<u>\$ 212,793</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 212,793</b>	3

Facility Name &amp; ID Number Rosewood Care Center of Peoria

# 0035352

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	\$ 2,829,643	\$	15-25	\$ 112,520	\$ 112,520	\$ 2,141,679	4
5				1991	4,140		25	166	166	2,475	5
6				1992	7,309		5			7,309	6
7				1992	2,756		10			2,756	7
8											8
		<b>Improvement Type**</b>									
9		Legal, Arch, Eng, Contractor Fees		1989	32,140		25	1,285	1,285	21,967	9
10		Capitalized Interest		1989	15,100		25	604	604	10,318	10
11		Site Improvement, Sewers, Landscaping, Traffic Study		1989	306,686		15-25	10,840	10,840	240,023	11
12		Entry Concrete Slab		1990	6,197		20	310	310	4,730	12
13		Irrigation System		1993	10,125		25	405	405	5,299	13
14		Parking Lot Expansion		1994	3,475		25	139	139	1,645	14
15		Parking Lot Expansion		1995	56,648		25	2,266	2,266	23,982	15
16		Irrigation System		1995	2,029		25	81	81	857	16
17		Parking Lot		1997	39,664		25	1,587	1,587	15,075	17
18		Walk-In Cooler		1989	5,770		10			5,770	18
19		Sinks		1989	3,744		10			3,744	19
20		Exhaust Hood		1989	4,620		10			4,620	20
21		Fire Supression System		1989	1,271		10			1,271	21
22		Generator		1989	14,937		10			14,937	22
23		Intercom System		1989	650		10			650	23
24		Facility Signs		1989	3,234		10			3,234	24
25		Baseboard Heater		1989	672		10			672	25
26		Carpet		1989	7,664		10			7,664	26
27		Cubicle Track		1989	6,294		10			6,294	27
28		Sign		1991	3,733		10			3,733	28
29		Monument Sign		1992	1,737		10			1,737	29
30		Ceramic Sink		1994	2,011		10			2,011	30
31		Parking Lot Sealing & Striping		2004	21,277		25	851	851	2,198	31
32		Backflow Preventers		2005	6,600		10	660	660	880	32
33		Roof		2005	89,411		10	7,451	7,451	7,451	33
34		Console Heat Pumps		2006	6,337		10	158	158	158	34
35		Door Closers		2005	2,870		15	96	96	96	35
36											36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Rosewood Care Center of Peoria

# 0035352

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	Fire Alarm Panel Control	2006	\$ 2,592	\$	10	\$ 86	\$ 86	\$ 86	37
38	Steel Doors	2006	4,920		20	21	21	21	38
39									39
40									40
41	Leasehold Improvements - Facility:								41
42	Pave Driveway	1994	2,822		7			2,822	42
43	Painting/Baseboards/Carpeting	1995	33,169		7			33,169	43
44	Cabinet Work	1995	1,868		7			1,868	44
45	Widen Activity Door	1996	2,659		7			2,659	45
46	Painting	1996	3,600		7			3,600	46
47	Carpeting/Undercounter Refig/Cabinets/Plants	1998	16,121	767	7	767		16,121	47
48	Wallpaper/Mini Blinds	1999	12,830	1,260	7	1,260		12,830	48
49	Ceiling Tiles	2000	991	142	7	142		813	49
50	Computer Cabling	2000	2,392	342	7	342		1,909	50
51	Door Alarm System	2000	3,143	449	7	449		2,619	51
52	Computer Receptacles	2001	214	31	7	31		169	52
53	Seal Parking Lot	2002	6,330	904	7	904		4,445	53
54	Painting	2003	3,167	452	7	452		1,545	54
55	Painting/Wallpaper	2004	6,220	889	7	889		1,852	55
56	Wallcovering	2004	4,164	595	7	595		1,190	56
57	Carpet & Vinyl Base	2006	8,941	532	7	532		532	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)		\$ 3,614,887	\$ 6,363		\$ 145,889	\$ 139,526	\$ 2,633,485	70

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

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 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	\$ 127,171	\$ 1,797	\$ 17,685	\$ 15,888	5-10 Yrs	\$ 78,420	71
72	Current Year Purchases	30,296		1,326	1,326	5-10 Yrs	1,326	72
73	Fully Depreciated Assets	368,358					368,358	73
74								74
75	TOTALS	\$ 525,825	\$ 1,797	\$ 19,011	\$ 17,214		\$ 448,104	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	\$	\$	\$ 4,296	\$ 4,296	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	13,402		733	733	4 Yrs	733	77
78	Senior Living Services	Various	2006	2,740		171	171	4 Yrs	171	78
79										79
80	TOTALS			\$ 16,142	\$	\$ 5,200	\$ 5,200		\$ 904	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)	\$ 4,369,647	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,160	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,100	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 161,940	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,082,493	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Schedule Not Applicable

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p><b>N/A - ONLY HIRE CERTIFIED AIDES</b> If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

## 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	\$	23,004	\$ 291,479	\$	23,004	\$ 291,479	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,567	33,996		2,567	33,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		21,736	290,799	6,145	21,736	296,944	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				197,751		197,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Lab, X-Ray and Other (specify): <u>Enterals</u>	39-8				40,353	21,535		61,888	13
14	<b>TOTAL</b>			\$	47,307	\$ 656,627	\$ 225,431	47,307	\$ 882,058	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352Report 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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 238,741	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>105,000</u> )	700,924		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,505		6
7	Other Prepaid Expenses	5,146		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 964,316	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	121,210		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(98,227)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 22,983	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 987,299	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 309,187	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,243		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,148		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,835		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	146,100		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 669,513	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 669,513	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 317,786	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 987,299	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>295,242</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>295,242</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>260,244</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(237,700)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>22,544</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>317,786</b>	<b>24</b> *

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

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352Report Period Beginning: 7/1/2005Ending: 6/30/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,908,752	1
2	Discounts and Allowances for all Levels	(2,251,593)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,657,159</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,109,369	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,109,369</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,800	13
14	Non-Patient Meals	5,942	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 10,742</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	23,464	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 23,464</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	543	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 543</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,801,277</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	830,575	31
32	Health Care	2,759,934	32
33	General Administration	1,159,277	33
<b>B. Capital Expense</b>			
34	Ownership	1,323,508	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	259,639	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,398,633</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>402,644</b>	<b>41</b>
42	<b>Income Taxes</b>	<b>(142,400)</b>	<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 260,244</b>	<b>43</b>

\* 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.

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

Facility Name & ID Number Rosewood Care Center of Peoria

# 0035352

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	1,930	2,029	\$ 59,491	\$ 29.32	1
2	Assistant Director of Nursing	1,913	2,012	49,900	24.80	2
3	Registered Nurses	11,510	12,105	289,272	23.90	3
4	Licensed Practical Nurses	15,077	15,856	323,801	20.42	4
5	CNAs & Orderlies	60,926	64,075	709,584	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,727	3,920	64,186	16.37	8
9	Activity Director					9
10	Activity Assistants	5,166	5,433	56,057	10.32	10
11	Social Service Workers	3,357	3,531	35,394	10.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,714	21,784	199,700	9.17	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	15,158	15,941	142,827	8.96	18
19	Laundry	4,562	4,798	39,640	8.26	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,142	11,717	142,024	12.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,495	4,727	61,920	13.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,677	167,928	\$ 2,173,796 *	\$ 12.94	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	352	\$ 8,095	1-3	35
36	Medical Director	Contract	16,470	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	15	308	11-3	44
45	Social Service Consultant	25	500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	392	\$ 25,373		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,346	\$ 49,568	10-3	50
51	Licensed Practical Nurses	7,054	236,136	10-3	51
52	Certified Nurse Assistants/Aides	1,423	29,480	10-3	52
53	TOTAL (lines 50 - 52)	9,823	\$ 315,184		53





**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 - \$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. \$ 64,357 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. \$ 5,942
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF PEORIA  
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 PEORIA  
IDPH ID #0035352  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 6,033</u>
	<u>\$ 6,033</u>

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

ROSEWOOD CARE CENTER OF PEORIA  
IDPH ID #0035352  
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	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 MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, 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.
PEORIA 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.