

		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: 0042341

Facility Name: Rosewood Care Center Northbrook

Address: 4101 Lake Cook Road Northbrook 60062
 Number City Zip Code

County: Cook

Telephone Number: (847) 562-1770 Fax # ()

HFS ID Number: 431660454001

Date of Initial License for Current Owners: 6/22/1998

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 E. 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 Northbrook# 0042341 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>147</u>	Skilled (SNF)	<u>147</u>	<u>53,655</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>147</u>	TOTALS	<u>147</u>	<u>53,655</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>2,608</u>	<u>2,608</u>	8
9	SNF/PED					9
10	ICF	<u>25,844</u>	<u>6,908</u>		<u>32,752</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,844</u>	<u>6,908</u>	<u>2,608</u>	<u>35,360</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.90%

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

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

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

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

NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 6/22/98

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

YES Date 6/22/98 NO

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

YES NO If YES, enter number of beds certified 30 and days of care provided 2,608Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Northbrook # 0042341 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	246,111	27,661	6,994	280,766		280,766	651	281,417		1
2	Food Purchase		170,605		170,605		170,605	(2,569)	168,036		2
3	Housekeeping	163,106	32,739		195,845		195,845		195,845		3
4	Laundry	51,475	13,486		64,961		64,961		64,961		4
5	Heat and Other Utilities			191,667	191,667		191,667		191,667		5
6	Maintenance	30,618	9,880	117,125	157,623		157,623	32,435	190,058		6
7	Other (specify):* Sanitation			11,509	11,509		11,509		11,509		7
8	TOTAL General Services	491,310	254,371	327,295	1,072,976		1,072,976	30,517	1,103,493		8
	B. Health Care and Programs										
9	Medical Director			8,575	8,575		8,575		8,575		9
10	Nursing and Medical Records	2,207,402	166,430		2,373,832		2,373,832		2,373,832		10
10a	Therapy	69,314	992	136,022	206,328		206,328	109,845	316,173		10a
11	Activities	62,238	3,160	2,256	67,654		67,654		67,654		11
12	Social Services	70,938		1,662	72,600		72,600		72,600		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,409,892	170,582	148,515	2,728,989		2,728,989	109,845	2,838,834		16
	C. General Administration										
17	Administrative	14,774		162,068	176,842		176,842	(12,810)	164,032		17
18	Directors Fees										18
19	Professional Services			12,796	12,796		12,796	50,850	63,646		19
20	Dues, Fees, Subscriptions & Promotions			44,973	44,973		44,973	(13,940)	31,033		20
21	Clerical & General Office Expenses	182,554	29,715	17,374	229,643		229,643	156,610	386,253		21
22	Employee Benefits & Payroll Taxes			369,917	369,917		369,917	30,413	400,330		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,342	1,342		1,342		1,342		24
25	Other Admin. Staff Transportation			3,514	3,514		3,514	16,348	19,862		25
26	Insurance-Prop.Liab.Malpractice			67,699	67,699		67,699	15,228	82,927		26
27	Other (specify):*										27
28	TOTAL General Administration	197,328	29,715	679,683	906,726		906,726	242,699	1,149,425		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,098,530	454,668	1,155,493	4,708,691		4,708,691	383,061	5,091,752		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 Northbrook #0042341 Report Period Beginning: 7/1/05 Ending: 6/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			1,950	1,950	1,950	278,542	280,492			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			964,479	964,479	964,479	(454,146)	510,333			32
33	Real Estate Taxes			78,326	78,326	78,326		78,326			33
34	Rent-Facility & Grounds			770,771	770,771	770,771	(758,362)	12,409			34
35	Rent-Equipment & Vehicles			17,332	17,332	17,332		17,332			35
36	Other (specify):*										36
37	TOTAL Ownership			1,832,858	1,832,858	1,832,858	(933,966)	898,892			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		98,728	13,168	111,896	111,896		111,896			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			80,484	80,484	80,484		80,484			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		98,728	93,652	192,380	192,380		192,380			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,098,530	553,396	3,082,003	6,733,929	6,733,929	(550,905)	6,183,024			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 Northbrook

0042341

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	(2,404)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,500)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,622)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	2		13
14	Non-Care Related Interest	(964,479)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,512)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,847)	20		28
29	Other-Attach Schedule Marketing Salary	(70,569)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,064,098)		\$	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)	513,193	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 513,193		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (550,905)		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.

		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 Northbrook

ID# 0042341

Report Period Beginning: 7/1/05

Ending: 6/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (70,569)	21
2			
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49	Total	(70,569)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Northbrook

0042341

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	651	0	0	0	0	0	0	0	0	651	1
2	Food Purchase	(2,569)	0	0	0	0	0	0	0	0	0	0	(2,569)	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	1,862	30,573	0	0	0	0	0	0	0	0	32,435	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,569)	1,862	31,224	0	30,517	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	109,845	0	0	0	0	0	0	0	0	0	109,845	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	109,845	0	0	0	0	0	0	0	0	0	109,845	16
	C. General Administration													
17	Administrative	0	(162,068)	149,258	0	0	0	0	0	0	0	0	(12,810)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	50,850	0	0	0	0	0	0	0	0	50,850	19
20	Fees, Subscriptions & Promotions	(15,359)	0	1,419	0	0	0	0	0	0	0	0	(13,940)	20
21	Clerical & General Office Expenses	(72,069)	0	228,679	0	0	0	0	0	0	0	0	156,610	21
22	Employee Benefits & Payroll Taxes	0	0	30,413	0	0	0	0	0	0	0	0	30,413	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	16,348	0	0	0	0	0	0	0	0	16,348	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	9,437	0	0	0	0	0	0	0	0	15,228	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(87,428)	(156,277)	486,404	0	242,699	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(89,997)	(44,570)	517,628	0	383,061	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Northbrook # 0042341 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	266,207	12,335	0	0	0	0	0	0	0	0	278,542	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(974,101)	519,955	0	0	0	0	0	0	0	0	0	(454,146)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(770,771)	12,409	0	0	0	0	0	0	0	0	(758,362)	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	TOTAL Ownership	(974,101)	15,391	24,744	0	(933,966)	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)	(1,064,098)	(29,179)	542,372	0	(550,905)	45							

Facility Name & ID Number Rosewood Care Center Northbrook

0042341

Report Period Beginning:

7/1/05

Ending:

6/30/06

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 152,697	HSM Management Services, Inc.	0.00%	\$	\$ (152,697)	1
2	V	17 Administrative Fee	9,371	Midwest Administrative Servcies. Inc.	0.00%		(9,371)	2
3	V							3
4	V	10a Therapy	136,022	Rosewood Therapy Services, Inc.	0.00%	245,867	109,845	4
5	V							5
6	V	34 Rent	770,771	Northbrook Real Estate, Inc.	0.00%		(770,771)	6
7	V	30 Depreciation		Northbrook Real Estate, Inc.	0.00%	266,011	266,011	7
8	V	32 Interest		Northbrook Real Estate, Inc.	0.00%	519,955	519,955	8
9	V	26 Property Insurance		Northbrook Real Estate, Inc.	0.00%	5,791	5,791	9
10	V							10
11	V	6 Repair & Maintenance	12,081	Senior Living Services, Inc.	0.00%	13,943	1,862	11
12	V	30 Depreciation		Senior Living Services, Inc.	0.00%	196	196	12
13	V							13
14	Total		\$ 1,080,942			\$ 1,051,763	\$ * (29,179)	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 Northbrook# 0042341Report 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%	\$ 118,833	\$ 118,833		15	
16	V	21	See Schedule VIII		HSM Management Services, Inc.	0.00%	198,064	198,064		16	
17	V	22	See Schedule VIII		HSM Management Services, Inc.	0.00%	26,346	26,346		17	
18	V	25	See Schedule VIII		HSM Management Services, Inc.	0.00%	14,964	14,964		18	
19	V	30	See Schedule VIII		HSM Management Services, Inc.	0.00%	10,022	10,022		19	
20	V	34	See Schedule VIII		HSM Management Services, Inc.	0.00%	11,895	11,895		20	
21	V	19	See Schedule VIII		HSM Management Services, Inc.	0.00%	35,144	35,144		21	
22	V	26	See Schedule VIII		HSM Management Services, Inc.	0.00%	7,544	7,544		22	
23	V	6	See Schedule VIII		HSM Management Services, Inc.	0.00%	29,835	29,835		23	
24	V	20	See Schedule VIII		HSM Management Services, Inc.	0.00%	1,030	1,030		24	
25	V									25	
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	651	651		26	
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	738	738		27	
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	30,425	30,425		28	
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	15,706	15,706		29	
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	389	389		30	
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	30,615	30,615		31	
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	4,067	4,067		32	
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,384	1,384		33	
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,893	1,893		34	
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	2,313	2,313		35	
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	514	514		36	
37	V									37	
38	V									38	
39	Total			\$			\$ 542,372	\$ *	542,372	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 Northbrook # 0042341 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%	1,037,719	3	6.50%	Salary	\$ 72,194	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	454,419	3	6.50%	Salary	31,614	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	\$ 103,808		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 Northbrook

0042341

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	\$ 5,543,957	\$ 73,383	1
2	21	Salaries - Others	Total Cost	85,233,641	18	2,665,906	5,543,957	173,402	2
3	22	Payroll Taxes	Total Cost	85,233,641	18	251,062	5,543,957	16,330	3
4	22	Employee Benefits	Total Cost	85,233,641	18	102,624	5,543,957	6,675	4
5	25	Travel	Total Cost	85,233,641	18	230,054	5,543,957	14,964	5
6	30	Depreciation	Total Cost	85,233,641	18	154,087	5,543,957	10,022	6
7	34	Building Rent	Total Cost	85,233,641	18	182,875	5,543,957	11,895	7
8	19	Professional Services	Total Cost	85,233,641	18	540,314	5,543,957	35,144	8
9	21	Telephone	Total Cost	85,233,641	18	175,406	5,543,957	11,409	9
10	26	Insurance	Total Cost	85,233,641	18	115,979	5,543,957	7,544	10
11	21	Taxes, Licenses, Office Supplies	Total Cost	85,233,641	18	203,759	5,543,957	13,253	11
12	6	Maintenance	Total Cost	85,233,641	18	100,147	5,543,957	6,514	12
13	20	Dues & Subscriptions	Total Cost	85,233,641	18	15,838	5,543,957	1,030	13
14	17	Direct - Admin	Direct Cost	1	1	45,450	45,450	1	45,450
15	17	Direct - Admin	Direct Cost	17	17	868,231	868,231	0	0
16	22	Direct - Payroll Taxes	Direct Cost	1	1	3,341	1	3,341	16
17	22	Direct - Payroll Taxes	Direct Cost	17	17	63,604	0	0	17
18	30	Direct - Depreciation	Direct Cost	1	1	0	1	0	18
19	30	Direct - Depreciation	Direct Cost	17	17	575	0	0	19
20	25	Direct - Travel	Direct Cost	1	1	0	1	0	20
21	25	Direct - Travel	Direct Cost	17	17	238	0	0	21
22	6	Direct - Maintenance	Direct Cost	1	1	23,321	1	23,321	22
23	6	Direct - Maintenance	Direct Cost	17	17	314,268	0	0	23
24									24
25	TOTALS					\$ 7,185,274	\$ 4,707,782	\$ 453,677	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Northbrook

0042341

Report Period Beginning:

7/1/05

Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost 85,233,641	18	\$ 10,015	\$ 10,015	5,543,957	\$ 651	1
2	6	Maintenance	Total Cost 85,233,641	18	11,176		5,543,957	727	2
3	17	Salaries - Officers	Total Cost 85,233,641	18	467,751	467,751	5,543,957	30,425	3
4	19	Professional Services	Total Cost 85,233,641	18	241,473		5,543,957	15,706	4
5	20	Dues & Subscriptions	Total Cost 85,233,641	18	5,983		5,543,957	389	5
6	21	Salaries - Other	Total Cost 85,233,641	18	400,855	400,855	5,543,957	26,073	6
7	21	Clerical & Office Supplies	Total Cost 85,233,641	18	69,834		5,543,957	4,542	7
8	22	Payroll Taxes & Empl. Benefits	Total Cost 85,233,641	18	62,532		5,543,957	4,067	8
9	25	Travel	Total Cost 85,233,641	18	21,283		5,543,957	1,384	9
10	26	Insurance	Total Cost 85,233,641	18	29,099		5,543,957	1,893	10
11	30	Depreciation	Total Cost 85,233,641	18	30,041		5,543,957	1,954	11
12	34	Building Rent	Total Cost 85,233,641	18	7,908		5,543,957	514	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	359		1	359	15
16	30	Direct - Depreciation	Direct Cost 17	17	5,063				16
17	6	Direct - Maintenance	Direct Cost 1	1	11		1	11	17
18	6	Direct - Maintenance	Direct Cost 17	17	3,776				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,388,575	\$ 900,037		\$ 88,695	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	National City		X	Mortgage	Varies	2/03	\$ 6,700,000	\$ 0	7/05	LIBOR+2	\$ 70,077	1								
2	Commerce Bank		X	Refinance Mortgage	Varies	9/05	12,500,000	12,500,000	3/08	LIBOR+1.8%	647,653	2								
3	Less: Related Party Income Offset										(212,278)	3								
4	Interest Income										(9,622)	4								
5	Amortization of Loan Fees										14,503	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 19,200,000	\$ 12,500,000			\$ 510,333	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 19,200,000	\$ 12,500,000			\$ 510,333	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Northbrook# 0042341 Report Period Beginning: 7/1/05Ending: 6/30/06

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	384,212	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.)			\$	381,133	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,079)	3														
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	81,405	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	78,326	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
2001	<u>176,848</u>	<u>8</u>	<table border="1"> <thead> <tr> <th colspan="2">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </tbody> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
2002	<u>157,789</u>	<u>9</u>																	
2003	<u>161,507</u>	<u>10</u>																	
2004	<u>307,924</u>	<u>11</u>																	
2005	<u>126,709</u>	<u>12</u>																	
2004 Payment = \$227,171																			
2005 Payment = \$153,962																			
Accrual = Overpayment of 2005 tax bill (-27,253) + 1/2 of estimated 2006 tax bill (108,658)																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042341

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>04-06-101-007-0000</u>	<u>4101 Kingston Rd, Northbrook</u>	\$ <u>67,982.57</u>	\$ <u>67,982.57</u>
2. <u>04-06-101-006-0000</u>	<u>4101 Kingston Rd, Northbrook</u>	\$ <u>58,726.18</u>	\$ <u>58,726.18</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>126,708.75</u>	\$ <u>126,708.75</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 Northbrook

0042341 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,834 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 2

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>6.6 Acres</u>	<u>1998</u>	<u>\$ 1,313,000</u>	1
2					2
3	TOTALS	6.6 Acres		\$ 1,313,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Northbrook

0042341

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	147			1998	\$ 8,660,744	\$	25-40	\$ 236,043	\$ 236,043	\$ 1,889,402	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fence Installation		1998	1,900		7			1,900	9
10		Patient Monitoring System		1998	54,214		7	1,226	1,226	54,214	10
11		Signs		1998	21,364		7	487	487	21,364	11
12		Cabinets		1998	11,679		7	265	265	11,679	12
13		Drains		1998	3,833		7	86	86	3,833	13
14		Stone Pavers		1998	9,661		7	219	219	9,661	14
15		Handicap Rails		1998	23,313		7	529	529	23,313	15
16		Sprinkler Water Pumps		1998	37,340		7	845	845	37,340	16
17		Generator		1998	74,806		7	1,689	1,689	74,806	17
18		Security Monitoring System		1998	22,221		7	504	504	22,221	18
19		Paging Systems		1998	46,099		7	1,041	1,041	46,099	19
20		Plumbing for Lawn Irrigation		1998	12,549		7	283	283	12,549	20
21		Run Conduit Wire		2003	7,350		40	184	184	552	21
22		Seal and Restripe Parking Lot		2003	5,635		25	226	226	659	22
23		Heating Coils		2005	8,677		10	867	867	867	23
24		Sump Pump		2006	2,634		10	132	132	132	24
25		Heat Pumps		2006	3,447		10	115	115	115	25
26											26
27											27
28											28
29											29
30		Facility Leaseholds:									30
31		Computer Cabling		2001	3,230	461	7	461		2,537	31
32		TV Lounge Carpet		2002	2,870	410	7	410		1,777	32
33		Carpet		2002	3,104	443	7	443		1,736	33
34		Concrete Floor Coating		2005	3,300	471	7	471		511	34
35		Painting		2006	3,440	165	7	165		165	35
36		Continued on Next Page									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 Northbrook**

0042341

Report Period Beginning:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	9,023,410	\$	1,950	\$	246,691	\$	244,741	\$	2,217,432	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 Northbrook # 0042341 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	\$ 183,207	\$	\$ 26,309	\$ 26,309	5-10 Yrs	\$ 111,635	71
72	Current Year Purchases	25,073		1,539	1,539	5-10 Yrs	1,539	72
73	Fully Depreciated Assets	369,981					369,981	73
74								74
75	TOTALS	\$ 578,261	\$	\$ 27,848	\$ 27,848		\$ 483,155	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management Svcs	Various	Various	\$	\$	4,918	\$ 4,918	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	15,342		839	839	4 Yrs	839	77
78	Senior Living Services	Various	2006	3,136		196	196	4 Yrs	196	78
79										79
80	TOTALS			\$ 18,478	\$	\$ 5,953	\$ 5,953		\$ 1,035	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,933,149	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,950	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 280,492	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 278,542	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,701,622	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rosewood Care Center Northbrook # 0042341 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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	\$	4,258	\$ 100,384	\$	4,258	\$ 100,384	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		698	3,766		698	3,766	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		6,220	141,717	992	6,220	142,709	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				78,950		78,950	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				13,168	19,778		32,946	13
14	TOTAL			\$	11,176	\$ 259,035	\$ 99,720	11,176	\$ 358,755	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 Northbrook# 0042341Report 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	\$ 994,309	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 62,000)	1,181,402		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,385		6
7	Other Prepaid Expenses	9,689		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,192,785	\$	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	15,944		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,726)		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)	\$ 9,218	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,202,003	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	15,097,330		29
30	Accrued Salaries Payable	212,626		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,324		31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,405		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(197,600)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 15,335,107	\$	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)	\$ 15,335,107	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (13,133,104)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,202,003	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (11,997,274)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (11,997,274)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,135,830)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,135,830)	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)	\$ (13,133,104)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Northbrook# 0042341Report 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	\$ 5,493,639	1
2	Discounts and Allowances for all Levels	(607,679)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,885,960	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	496,403	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 496,403	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	2,404	14
15	Telephone, Television and Radio	1,500	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)	\$ 7,504	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,622	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,010	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,010	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,400,499	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,072,976	31
32	Health Care	2,728,989	32
33	General Administration	906,726	33
B. Capital Expense			
34	Ownership	1,832,858	34
C. Ancillary Expense			
35	Special Cost Centers	111,896	35
36	Provider Participation Fee	80,484	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,733,929	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,333,430)	41
42	Income Taxes	197,600	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,135,830)	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 Northbrook

0042341

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	2,031	2,154	\$ 78,580	\$ 36.48	1
2	Assistant Director of Nursing	1,896	2,011	65,986	32.81	2
3	Registered Nurses	31,253	33,155	1,079,986	32.57	3
4	Licensed Practical Nurses	2,861	3,035	69,716	22.97	4
5	CNAs & Orderlies	69,035	73,237	878,581	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,366	3,571	69,314	19.41	8
9	Activity Director					9
10	Activity Assistants	4,958	5,259	62,238	11.83	10
11	Social Service Workers	4,049	4,296	70,938	16.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,478	23,847	246,111	10.32	15
16	Dishwashers					16
17	Maintenance Workers	2,021	2,144	30,618	14.28	17
18	Housekeepers	17,491	18,556	163,106	8.79	18
19	Laundry	5,492	5,826	51,475	8.84	19
20	Administrator	472	501	14,774	29.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,589	12,294	182,554	14.85	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	2,121	2,250	34,553	15.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,113	192,136	\$ 3,098,530 *	\$ 16.13	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	290	\$ 6,994	1-3	35
36	Medical Director	Contract	8,575	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	85	2,256	11-3	44
45	Social Service Consultant	60	1,662	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	435	\$ 19,487		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ Section N/A		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Northbrook

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 - \$8,114
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,954 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. \$ 80,484
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. \$ 2,404
- (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 NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 3,514</u>
	<u><u>\$ 3,514</u></u>

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

ROSEWOOD CARE CENTER OF NORTHBROOK
IDPH ID #0042341
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 MOLINE	MOLINE, 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.
NORTHBROOK 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