

		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: 0041764

Facility Name: Rosewood Care Center of St Charles

Address: 850 Dunham Road St Charles 60174
 Number City Zip Code

County: Kane

Telephone Number: (630) 443-4400 **Fax #** (630) 443-4460

HFS ID Number: 431683970001

Date of Initial License for Current Owners: 4/7/1999

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.

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, L.L.C.
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles

0041764 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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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			5,716	5,716	8
9	SNF/PED					9
10	ICF	6,751	17,269		24,020	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,751	17,269	5,716	29,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.74%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 6/28/1999

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/28/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 38 and days of care provided 5,716

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRAUAL 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.

Facility Name & ID Number Rosewood Care Center of St Charles # 0041764 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	195,844	17,627	6,901	220,372		220,372	595	220,967		1
2	Food Purchase		143,141		143,141		143,141	(1,458)	141,683		2
3	Housekeeping	126,046	28,268		154,314		154,314		154,314		3
4	Laundry	33,181	9,787		42,968		42,968		42,968		4
5	Heat and Other Utilities			126,707	126,707		126,707		126,707		5
6	Maintenance	32,197	18,351	217,543	268,091		268,091	(44,350)	223,741		6
7	Other (specify):* Sanitation			7,652	7,652		7,652		7,652		7
8	TOTAL General Services	387,268	217,174	358,803	963,245		963,245	(45,213)	918,032		8
	B. Health Care and Programs										
9	Medical Director			15,168	15,168		15,168		15,168		9
10	Nursing and Medical Records	1,478,703	154,153	499,154	2,132,010		2,132,010		2,132,010		10
10a	Therapy	102,137	6,643	307,447	416,227		416,227	50,897	467,124		10a
11	Activities	62,769	4,363		67,132		67,132		67,132		11
12	Social Services	41,119		1,881	43,000		43,000		43,000		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,684,728	165,159	823,650	2,673,537		2,673,537	50,897	2,724,434		16
	C. General Administration										
17	Administrative	20,375		232,872	253,247		253,247	(76,258)	176,989		17
18	Directors Fees			9,254	9,254		9,254		9,254		18
19	Professional Services							46,446	46,446		19
20	Dues, Fees, Subscriptions & Promotions			48,432	48,432	995	49,427	(7,536)	41,891		20
21	Clerical & General Office Expenses	163,016	29,962	17,820	210,798		210,798	141,038	351,836		21
22	Employee Benefits & Payroll Taxes			273,968	273,968		273,968	29,250	303,218		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,903	1,903	(995)	908		908		24
25	Other Admin. Staff Transportation			8,193	8,193		8,193	14,932	23,125		25
26	Insurance-Prop.Liab.Malpractice			55,661	55,661		55,661	14,410	70,071		26
27	Other (specify):*										27
28	TOTAL General Administration	183,391	29,962	648,103	861,456		861,456	162,282	1,023,738		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,255,387	412,295	1,830,556	4,498,238		4,498,238	167,966	4,666,204		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of St Charles #0041764 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			2,720	2,720	2,720	220,967	223,687			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						400,828	400,828			32
33	Real Estate Taxes			166,033	166,033	166,033		166,033			33
34	Rent-Facility & Grounds			1,095,610	1,095,610	1,095,610	(1,084,275)	11,335			34
35	Rent-Equipment & Vehicles			15,940	15,940	15,940		15,940			35
36	Other (specify):* Mortgage Insur.						63,661	63,661			36
37	TOTAL Ownership			1,280,303	1,280,303	1,280,303	(398,819)	881,484			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		148,380	27,688	176,068	176,068		176,068			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678	59,678		59,678			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		148,380	87,366	235,746	235,746		235,746			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,255,387	560,675	3,198,225	6,014,287	6,014,287	(230,853)	5,783,434			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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	(1,046)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,293)	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	(13,162)	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	(2,441)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,391)	20		28
29	Other-Attach Schedule Marketing Salary	(63,543)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,288)		\$	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)	(139,565)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (139,565)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (230,853)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of St Charles

ID# 0041764

Report Period Beginning: 7/1/05

Ending: 6/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (63,543)	21
2			
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49	Total	(63,543)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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	595	0	0	0	0	0	0	0	0	595	1
2	Food Purchase	(1,458)	0	0	0	0	0	0	0	0	0	0	(1,458)	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	(78,353)	34,003	0	0	0	0	0	0	0	0	(44,350)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,458)	(78,353)	34,598	0	(45,213)	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	50,897	0	0	0	0	0	0	0	0	0	50,897	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	50,897	0	0	0	0	0	0	0	0	0	50,897	16
	C. General Administration													
17	Administrative	0	(232,872)	156,614	0	0	0	0	0	0	0	0	(76,258)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	46,446	0	0	0	0	0	0	0	0	46,446	19
20	Fees, Subscriptions & Promotions	(8,832)	0	1,296	0	0	0	0	0	0	0	0	(7,536)	20
21	Clerical & General Office Expenses	(67,836)	0	208,874	0	0	0	0	0	0	0	0	141,038	21
22	Employee Benefits & Payroll Taxes	0	0	29,250	0	0	0	0	0	0	0	0	29,250	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	14,932	0	0	0	0	0	0	0	0	14,932	25
26	Insurance-Prop.Liab.Malpractice	0	5,791	8,619	0	0	0	0	0	0	0	0	14,410	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(76,668)	(227,081)	466,031	0	162,282	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,126)	(254,537)	500,629	0	167,966	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of St Charles # 0041764 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	209,744	11,223	0	0	0	0	0	0	0	0	220,967	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,162)	413,990	0	0	0	0	0	0	0	0	0	400,828	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,095,610)	11,335	0	0	0	0	0	0	0	0	(1,084,275)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	63,661	0	0	0	0	0	0	0	0	0	63,661	36
37	TOTAL Ownership	(13,162)	(408,215)	22,558	0	(398,819)	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)	(91,288)	(662,752)	523,187	0	(230,853)	45							

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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	\$ 156,123	HSM Management Services, Inc.	0.00%	\$	\$ (156,123)	1
2	V	17 Administrative Fee	76,749	Midwest Administrative Services, Inc.	0.00%		(76,749)	2
3	V							3
4	V	10a Therapy	307,447	Rosewood Therapy Services, Inc.	0.00%	358,344	50,897	4
5	V							5
6	V	34 Rent	1,095,610	St. Charles Real Estate, L.L.C.	0.00%		(1,095,610)	6
7	V	30 Depreciation		St. Charles Real Estate, L.L.C.	0.00%	209,565	209,565	7
8	V	32 Interest		St. Charles Real Estate, L.L.C.	0.00%	413,990	413,990	8
9	V	36 Mortgage Insurance		St. Charles Real Estate, L.L.C.	0.00%	63,661	63,661	9
10	V	26 Property Insurance		St. Charles Real Estate, L.L.C.	0.00%	5,791	5,791	10
11	V							11
12	V	6 Repairs & Maintenance	94,970	Senior Living Services, Inc.	0.00%	16,617	(78,353)	12
13	V	30 Depreciation		Senior Living Services, Inc.	0.00%	179	179	13
14	Total		\$ 1,730,899			\$ 1,068,147	\$ * (662,752)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles# 0041764Report 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%	\$ 128,825	\$ 128,825	15	
16	V	21	See Schedule VIII		HSM Management Services, Inc.		0.00%	180,910	180,910	16	
17	V	22	See Schedule VIII		HSM Management Services, Inc.		0.00%	25,535	25,535	17	
18	V	25	See Schedule VIII		HSM Management Services, Inc.		0.00%	13,668	13,668	18	
19	V	30	See Schedule VIII		HSM Management Services, Inc.		0.00%	9,154	9,154	19	
20	V	34	See Schedule VIII		HSM Management Services, Inc.		0.00%	10,865	10,865	20	
21	V	19	See Schedule VIII		HSM Management Services, Inc.		0.00%	32,100	32,100	21	
22	V	26	See Schedule VIII		HSM Management Services, Inc.		0.00%	6,890	6,890	22	
23	V	6	See Schedule VIII		HSM Management Services, Inc.		0.00%	32,993	32,993	23	
24	V	20	See Schedule VIII		HSM Management Services, Inc.		0.00%	941	941	24	
25	V									25	
26	V	1	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	595	595	26	
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	1,010	1,010	27	
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	27,789	27,789	28	
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	14,346	14,346	29	
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	355	355	30	
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	27,964	27,964	31	
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	3,715	3,715	32	
33	V	25	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	1,264	1,264	33	
34	V	26	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	1,729	1,729	34	
35	V	30	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	2,069	2,069	35	
36	V	34	See Schedule VIII		Midwest Administrative Services, Inc.		0.00%	470	470	36	
37	V									37	
38	V									38	
39	Total			\$				\$ 523,187	\$ * 523,187	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles # 0041764 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%	1,043,972	2	5.94%	Salary	\$ 65,941	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	457,158	2	5.94%	Salary	28,875	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	\$ 94,816		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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	18	\$ 1,128,195	\$ 1,128,195	5,063,796	\$ 67,027	1
2	21	Salaries - Others	Total Cost	18	2,665,906	2,665,906	5,063,796	158,384	2
3	22	Payroll Taxes	Total Cost	18	251,062		5,063,796	14,916	3
4	22	Employee Benefits	Total Cost	18	102,624		5,063,796	6,097	4
5	25	Travel	Total Cost	18	230,054		5,063,796	13,668	5
6	30	Depreciation	Total Cost	18	154,087		5,063,796	9,154	6
7	34	Building Rent	Total Cost	18	182,875		5,063,796	10,865	7
8	19	Professional Services	Total Cost	18	540,314		5,063,796	32,100	8
9	21	Telephone	Total Cost	18	175,406		5,063,796	10,421	9
10	26	Insurance	Total Cost	18	115,979		5,063,796	6,890	10
11	21	Taxes, Licenses, & Ofc Sup	Total Cost	18	203,759		5,063,796	12,105	11
12	6	Maintenance	Total Cost	18	100,147		5,063,796	5,950	12
13	20	Dues & Subscriptions	Total Cost	18	15,838		5,063,796	941	13
14	17	Direct - Admin	Direct Cost	1	61,798	61,798	1	61,798	14
15	17	Direct - Admin	Direct Cost	17	851,883	851,883	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	4,522		1	4,522	16
17	22	Direct - Payroll Taxes	Direct Cost	17	62,423		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	0		1	0	18
19	30	Direct - Depreciation	Direct Cost	17	575		0	0	19
20	25	Direct - Travel	Direct Cost	1	0		1	0	20
21	25	Direct - Travel	Direct Cost	17	238		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	27,043		1	27,043	22
23	6	Direct - Maintenance	Direct Cost	17	310,546		0	0	23
24									24
25	TOTALS				\$ 7,185,274	\$ 4,707,782		\$ 441,881	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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	18	\$ 10,015	\$ 10,015	5,063,796	\$ 595	1
2	6	Maintenance	Total Cost	18	11,176		5,063,796	664	2
3	17	Salaries - Officers	Total Cost	18	467,751	467,751	5,063,796	27,789	3
4	19	Professional Services	Total Cost	18	241,473		5,063,796	14,346	4
5	20	Dues & Subscriptions	Total Cost	18	5,983		5,063,796	355	5
6	21	Salaries - Other	Total Cost	18	400,855	400,855	5,063,796	23,815	6
7	21	Clerical & Office Supplies	Total Cost	18	69,834		5,063,796	4,149	7
8	22	Payroll Taxes & Employee Ben.	Total Cost	18	62,532		5,063,796	3,715	8
9	25	Travel	Total Cost	18	21,283		5,063,796	1,264	9
10	26	Insurance	Total Cost	18	29,099		5,063,796	1,729	10
11	30	Depreciation	Total Cost	18	30,041		5,063,796	1,785	11
12	34	Building Rent	Total Cost	18	7,908		5,063,796	470	12
13	17	Direct - Admin Salaries	Direct Cost	1			1		13
14	17	Direct - Admin Salaries	Direct Cost	17	21,416	21,416			14
15	30	Direct - Depreciation	Direct Cost	1	284		1	284	15
16	30	Direct - Depreciation	Direct Cost	17	5,138				16
17	6	Direct - Maintenance	Direct Cost	1	346		1	346	17
18	6	Direct - Maintenance	Direct Cost	17	3,441				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,388,575	\$ 900,037		\$ 81,306	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Capmark		X	Mortgage	\$63,582.00	11/1/04	\$ 13,107,300	\$ 12,864,118	12/1/39	4.69%	\$ 607,310	1					
2	Less: Related Party Interest Income Offset											(195,878)	2				
3	Amortization of Loan Fees											4,690	3				
4	Less: Interest Income Offset											(13,162)	4				
5	Real Estate Co. Interest Income											(2,132)	5				
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$63,582.00		\$ 13,107,300	\$ 12,864,118			\$ 400,828	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 13,107,300	\$ 12,864,118			\$ 400,828	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,661 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0041764

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>09-26-226-008</u>	<u></u>	\$ <u>144,640.92</u>	\$ <u>144,640.92</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>144,640.92</u>	\$ <u>144,640.92</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 St Charles

0041764 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel 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>8.35 acres</u>	<u>1994</u>	<u>\$ 1,714,398</u>	1
2					2
3	TOTALS	8.35 acres		\$ 1,714,398	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of St Charles**

0041764

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	109			1999	\$ 5,353,402	\$	40	\$ 133,835	\$ 133,835	\$ 936,845	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Development			1999	555,639		25	22,226	22,226	155,581	9
10	Automatic Doors			2002	12,016		10	1,202	1,202	5,409	10
11	Convert Private Rooms to Semi-Private			2002	95,679		40	2,392	2,392	10,764	11
12	Seal & Stripe Parking Lot			2004	6,024		2	3,012	3,012	5,020	12
13	Water Softener			2005	8,323		10	763	763	763	13
14	Heat Exchanger for Boiler			2006	3,573		10	149	149	149	14
15	Heat Pumps			2006	6,894		10	230	230	230	15
16	Heat Exchanger			2006	3,764		10	125	125	125	16
17											17
18											18
19											19
20											20
21	Facility Leaseholds:										21
22	Computer Cabling			2001	2,895	413	7	413		2,274	22
23	Vinyl Tile Flooring			2003	6,300	900	7	900		2,550	23
24	Painting & Decorating			2004	2,662	380	7	380		634	24
25	Vinyl Tile Flooring			2004	2,713	388	7	388		646	25
26	Drywall/Wallcovering			2005	4,880	639	7	639		639	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of St Charles**

0041764

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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 6,064,764	\$ 2,720		\$ 166,654	\$ 163,934	\$ 1,121,629	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of St Charles # 0041764 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	\$ 456,313	\$	\$ 50,293	\$ 50,293	5-10 Yrs	\$ 301,725	71
72	Current Year Purchases	26,357		1,303	1,303	5-10 Yrs	1,303	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 482,670	\$	\$ 51,596	\$ 51,596		\$ 303,028	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	\$	\$	\$ 4,492	\$ 4,492	4 Yrs	\$	76
77	Midwest Admin. Services	Various	2006	14,013		766	766	4 Yrs	766	77
78	Senior Living Services	Various	2006	2,865		179	179	4 Yrs	179	78
79										79
80	TOTALS			\$ 16,878	\$	\$ 5,437	\$ 5,437		\$ 945	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)	\$ 8,278,710	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,720	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 223,687	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 220,967	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,425,602	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rosewood Care Center of St Charles # 0041764 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Rosewood Care Center of St Charles# 0041764

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	\$	12,169	\$ 217,406	\$	12,169	\$ 217,406	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		834	24,547		834	24,547	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		11,961	116,391	6,643	11,961	123,034	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				130,765		130,765	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory, X-Ray, & Enterals Other (specify):	39-8				27,688	17,615		45,303	13
14	TOTAL			\$	24,964	\$ 386,032	\$ 155,023	24,964	\$ 541,055	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles# 0041764Report 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	\$ (540,536)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u>)	708,533		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,290		6
7	Other Prepaid Expenses	4,858		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 195,145	\$	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	19,450		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,743)		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)	\$ 12,707	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 207,852	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 130,632	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,800		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,862		31
32	Accrued Real Estate Taxes(Sch.IX-B)	146,087		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,100		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 477,481	\$	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)	\$ 477,481	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (269,629)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 207,852	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (319,760)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (319,760)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	50,131	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)	\$ 50,131	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)	\$ (269,629)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles# 0041764Report 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	\$ 6,319,493	1
2	Discounts and Allowances for all Levels	(1,440,488)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,879,005	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,192,507	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,192,507	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	3,575	13
14	Non-Patient Meals	1,046	14
15	Telephone, Television and Radio	4,293	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)	\$ 8,914	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,162	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,162	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	156	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 156	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,093,744	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	963,245	31
32	Health Care	2,673,537	32
33	General Administration	861,456	33
B. Capital Expense			
34	Ownership	1,280,303	34
C. Ancillary Expense			
35	Special Cost Centers	176,068	35
36	Provider Participation Fee	59,678	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,014,287	40
41	Income before Income Taxes (line 30 minus line 40)**	79,457	41
42	Income Taxes	(29,326)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 50,131	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

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				1
2	Assistant Director of Nursing	2,307	2,422	74,251	30.66
3	Registered Nurses	14,787	15,527	422,541	27.21
4	Licensed Practical Nurses	6,996	7,345	169,438	23.07
5	CNAs & Orderlies	54,185	56,893	731,793	12.86
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	6,001	6,301	102,137	16.21
9	Activity Director				9
10	Activity Assistants	5,022	5,273	62,769	11.90
11	Social Service Workers	3,217	3,378	41,119	12.17
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	20,435	21,456	195,844	9.13
16	Dishwashers				16
17	Maintenance Workers	2,240	2,352	32,197	13.69
18	Housekeepers	13,913	14,609	126,046	8.63
19	Laundry	4,211	4,421	33,181	7.51
20	Administrator	474	498	20,375	40.91
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	11,342	11,909	163,016	13.69
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	4,089	4,293	80,680	18.79
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	149,219	156,677	\$ 2,255,387 *	\$ 14.40 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	300	\$ 6,901	1-3 35
36	Medical Director	Contract	15,168	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			44
45	Social Service Consultant	105	1,881	12-3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	405	\$ 23,950	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,595	\$ 405,896	10-3 50
51	Licensed Practical Nurses	2,403	93,258	10-3 51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	10,998	\$ 499,154	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of St Charles

0041764

Report Period Beginning: 7/1/05

Ending: 6/30/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Total Administrator Cost on Line 17, Col. 1:				Workers' Compensation Insurance	\$ 58,638	IDPH License Fee	\$ 995		
Bart Becker	Administrator	0.00%	20,375	Unemployment Compensation Insurance	35,379	Advertising: Employee Recruitment	31,786		
Total Direct Administrator Cost from HSM Mgmt, Line 17, Col. 7				FICA Taxes	171,516	Health Care Worker Background Check			
Bart Becker	Administrator	0.00%	61,798	Employee Health Insurance	2,747	(Indicate # of checks performed <u>94</u>)	940		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Meals		Patient Background Checks	200		
(List each licensed administrator separately.)				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	5,832		
\$ 82,173				Related Party Allocations	29,250	Misc. Dues/Subscriptions	6,674		
B. Administrative - Other				Tuition Reimbursement	159	Related Party Allocations	1,296		
Description			Amount	Employee Relations	2,582				
Management Fees			\$ 156,123	Employee Physicals	1,839	Less: Public Relations Expense	()		
Administrative Fees			76,749	Employee Uniforms	358	Non-allowable advertising	(2,441)		
TOTAL (agree to Schedule V, line 17, col. 3)				Recruitment Fees	750	Yellow page advertising	(3,391)		
(Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			\$ 41,891		
\$ 232,872				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount				Description	Amount	
C.J. Schlosser & Company	Accountant/Consultant		\$ 9,204	Section Not Applicable			Out-of-State Travel	\$	
	Legal Fees		50				In-State Travel		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				Seminar Expense	908
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 9,254				Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 908

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Rosewood Care Center of St Charles

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$6,017
- (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. \$ 62,168 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. \$ 59,678
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. \$ 1,046
- (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 ST. CHARLES, INC.
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 ST. CHARLES, INC.
IDPH ID #0041764
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2006

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 8,193</u>
	<u><u>\$ 8,193</u></u>

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

ROSEWOOD CARE CENTER OF ST. CHARLES, INC.
IDPH ID #0041764
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 NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, 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.
ST. CHARLES 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