		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0041780

Facility Name: ROSE GARDEN CONVALESCENT CTR

Address: 1629 GARDNER LANE (Number) PEORIA HEIGHTS (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

HFS ID Number: 36-4069174

Date of Initial License for Current Owners: 3/1/1996

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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)	SHERWIN I. RAY
	(Title)	PRESIDENT
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
	(Print Name and Title)	BOB KAGDA VICE PRESIDENT
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,951	2,951	8
9	SNF/PED					9
10	ICF	27,811	2,205		30,016	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,811	2,205	2,951	32,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.11%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 2,951

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,304	26,178	8,747	199,229		199,229		199,229			1
2	Food Purchase		164,197		164,197		164,197	(505)	163,692			2
3	Housekeeping	88,229	53,808		142,037		142,037		142,037			3
4	Laundry	43,234	11,939		55,173		55,173		55,173			4
5	Heat and Other Utilities			104,279	104,279		104,279	7	104,286			5
6	Maintenance	34,513	22,245	24,829	81,587		81,587	4,823	86,410			6
7	Other (specify):*			10,551	10,551		10,551	41	10,592			7
8	**TOTAL General Services**	330,280	278,367	148,406	757,053		757,053	4,366	761,419			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000		7,000			9
10	Nursing and Medical Records	1,407,253	101,973	6,759	1,515,985		1,515,985	30,069	1,546,054			10
10a	Therapy	62,251	1,878	105,543	169,672		169,672	14,760	184,432			10a
11	Activities	49,000	14,133		63,133		63,133		63,133			11
12	Social Services	13,285		4,190	17,475		17,475		17,475			12
13	CNA Training											13
14	Program Transportation			5,285	5,285		5,285		5,285			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,531,789	117,984	128,777	1,778,550		1,778,550	44,829	1,823,379			16
	C. General Administration											
17	Administrative	78,048		60,000	138,048		138,048	3,395	141,443			17
18	Directors Fees											18
19	Professional Services			246,030	246,030		246,030	(167,440)	78,590			19
20	Dues, Fees, Subscriptions & Promotions			44,573	44,573		44,573	(20,204)	24,369			20
21	Clerical & General Office Expenses	126,186	14,831	146,378	287,395		287,395	(88,129)	199,266			21
22	Employee Benefits & Payroll Taxes			306,397	306,397		306,397		306,397			22
23	Inservice Training & Education			4,710	4,710		4,710	1,039	5,749			23
24	Travel and Seminar			630	630		630	1,537	2,167			24
25	Other Admin. Staff Transportation			11,742	11,742		11,742	6,003	17,745			25
26	Insurance-Prop.Liab.Malpractice			59,206	59,206		59,206	1,295	60,501			26
27	Other (specify):*							42,857	42,857			27
28	**TOTAL General Administration**	204,234	14,831	879,666	1,098,731		1,098,731	(219,647)	879,084			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,066,303	411,182	1,156,849	3,634,334		3,634,334	(170,452)	3,463,882			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ROSE GARDEN CONVALESCENT CTR #0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,336	
	REPAIRS & MAINTENANCE		411	
			0	8,747
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		31,740	
	ELECTRICITY		53,408	
	WATER		11,155	
	CABLE TV - LOBBY		7,976	
			0	104,279
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,375	
	PAINTING & DECORATING		368	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,588	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,932	
	FIRE SERVICE		5,566	
			0	
			0	
			0	
			0	24,829
7	**OTHER**			
	SCAVENGER		10,551	
	SECURITY SERVICE		0	
			0	
			0	10,551
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,000	7,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		168	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,046	
	PHARMACY CONSULTANT	XVIII B 39-2	1,045	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	4,500	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	6,759
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		11,367	
	SPEECH THERAPY SERVICES		5,630	
	OCCUPATIONAL THERAPY SERVICES		9,320	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
	THERAPY CONTRACT SERVICES		68,426	
				105,543
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,190	
			0	4,190
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR **#0041780** **Report Period Beginning: 01/01/2007** **Ending: 12/31/2007**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,285	5,285
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	60,000	60,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	33,663	
	ADMINISTRATIVE CONSULTANTS	XIX C	150,000	
	PROFESSIONAL FEES	XIX C	62,367	
			0	246,030
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,039	
	EMPLOYEE WANT ADS	XIX F	16,177	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	448	
	LICENSES & PERMITS	XIX F	5,538	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	2,237	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	134	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				44,573
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		2,979	
	OUTSIDE CLERICAL SERVICES		98,460	
	PENALTIES / OVERDRAFT CHARGES	VI 18	26,207	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		55	
	TELEPHONE		14,007	
	MESSENGER SERVICE		4,670	
			0	146,378

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	155,688	
	UNEMPLOYMENT COMPENSATION	XIX D	55,648	
	WORKERS COMPENSATION INSURANC	XIX D	69,183	
	HOSPITALIZATION INSURANCE	XIX D	22,565	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,445	
	EMPLOYEE PHYSICAL EXAMS	XIX D	525	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	343	
	CHICAGO HEAD TAX	XIX D	0	
			0	306,397
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,710	
				4,710
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	630	
				630
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,742	
				11,742
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		59,206	
				59,206
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,156,849

ROSE GARDEN CONVALESCENT CTR
SCHEDULES
12/31/2007

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	164,197
LESS SALES TAX	(505)
NET FOOD	163,692
TOTAL PATIENT CENSUS	32,967
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	98,901
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	98,901
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	98,901
NET FOOD	163,692
DIVIDE TOTAL MEALS/YEAR	98,901
COST PER MEAL	1.66
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR #0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,709	13,709		13,709	98,069	111,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,179	118,179		118,179	292,218	410,397			32
33	Real Estate Taxes			28,334	28,334		28,334	4,156	32,490			33
34	Rent-Facility & Grounds			300,738	300,738		300,738	(300,738)				34
35	Rent-Equipment & Vehicles			68,463	68,463		68,463	(34,298)	34,165			35
36	Other (specify):*											36
37	TOTAL Ownership			529,423	529,423		529,423	59,407	588,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,906	128,760	236,666		236,666	10,681	247,347			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		107,906	188,985	296,891		296,891	10,681	307,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,066,303	519,088	1,875,257	4,460,648		4,460,648	(100,364)	4,360,284			45

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,773)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(505)	2		13
14	Non-Care Related Interest	(7,133)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,237)	20		17
18	Fines and Penalties	(26,207)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,118)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(20,039)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(27,913)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,925)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	(9,439)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,439)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (100,364)		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 Yes	2 No	3 Amount	4 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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ROSE GARDEN CONVALESCENT CTR

ID# 0041780

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING	$ (27,913)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,913)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(505)	0	0	0	0	0	0	0	0	0	0	(505)	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	7	0	0	0	0	0	0	0	7	5
6	Maintenance	0	0	0	4,823	0	0	0	0	0	0	0	4,823	6
7	Other (specify):*	0	0	0	41	0	0	0	0	0	0	0	41	7
8	**TOTAL General Services**	(505)	0	0	4,871	0	0	0	0	0	0	0	4,366	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	30,069	0	0	0	0	0	0	0	30,069	10
10a	Therapy	0	11,077	0	3,683	0	0	0	0	0	0	0	14,760	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	11,077	0	33,752	0	0	0	0	0	0	0	44,829	16
	C. General Administration													
17	Administrative	0	0	(60,000)	63,395	0	0	0	0	0	0	0	3,395	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,118)	0	(170,472)	5,150	0	0	0	0	0	0	0	(167,440)	19
20	Fees, Subscriptions & Promotions	(22,276)	0	0	2,072	0	0	0	0	0	0	0	(20,204)	20
21	Clerical & General Office Expenses	(54,120)	0	(96,000)	61,991	0	0	0	0	0	0	0	(88,129)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	1,039	0	0	0	0	0	0	0	1,039	23
24	Travel and Seminar	0	0	0	1,537	0	0	0	0	0	0	0	1,537	24
25	Other Admin. Staff Transportation	0	0	0	6,003	0	0	0	0	0	0	0	6,003	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,295	0	0	0	0	0	0	0	1,295	26
27	Other (specify):*	0	0	0	42,857	0	0	0	0	0	0	0	42,857	27
28	**TOTAL General Administration**	(78,514)	0	(326,472)	185,339	0	0	0	0	0	0	0	(219,647)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,019)	11,077	(326,472)	223,962	0	0	0	0	0	0	0	(170,452)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,773)	93,730	0	9,112	0	0	0	0	0	0	0	98,069	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,133)	269,591	0	29,760	0	0	0	0	0	0	0	292,218	32
33	Real Estate Taxes	0	0	0	4,156	0	0	0	0	0	0	0	4,156	33
34	Rent-Facility & Grounds	0	(300,738)	0	0	0	0	0	0	0	0	0	(300,738)	34
35	Rent-Equipment & Vehicles	0	(40,407)	0	6,109	0	0	0	0	0	0	0	(34,298)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,906)	22,176	0	49,137	0	0	0	0	0	0	0	59,407	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	10,681	0	0	0	0	0	0	0	0	0	10,681	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	10,681	0	0	0	0	0	0	0	0	0	10,681	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(90,925)	43,934	(326,472)	273,099	0	0	0	0	0	0	0	(100,364)	45

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				ROSE GARDEN CARE CENTER LLC		REAL ESTATE
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					SKOKIE	

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 300,738	ROSE GARDEN CARE CENTER LLC	100.00%	$	$ (300,738)	1
2	V	30	SL DEPRECIATION				88,640	88,640	2
3	V	32	INTEREST				265,820	265,820	3
4	V								4
5	V								5
6	V	10a	THERAPY SERVICES	105,541	CAREPLUS REHABILITATIVE SERVICES	100.00%		(105,541)	6
7	V	39	ANCILLARY SERVICES	101,777				(101,777)	7
8	V	10a	THERAPY SERVICES				116,618	116,618	8
9	V	39	ANCILLARY SERVICES				112,458	112,458	9
10	V	35	RENTAL INCOME	40,407				(40,407)	10
11	V	30	DEPRECIATION				5,090	5,090	11
12	V	32	EQUIPMENT LOAN INTEREST				3,771	3,771	12
13	V								13
14	Total			$ 548,463			$ 592,397	$ * 43,934	14

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 60,000	CAREPLUS MGMT INC	100.00%	$	$ (60,000)	15
16	V	19	ADMIN CONSULT FEES	150,000				(150,000)	16
17	V	19	DATA PROCESSING FEES	20,472				(20,472)	17
18	V	21	CLERICAL FEES	96,000				(96,000)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 326,472			$ 0	$ * (326,472)	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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. [X] 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)	
15	V	5	UTILITIES	$	CAREPLUS MGMT INC	100.00%	$ 7	$ 7	15
16	V	6	MAINT & REPAIRS				866	866	16
17	V	6	MAINTENANCE SALARIES				3,957	3,957	17
18	V	7	SECURITY				41	41	18
19	V	10	NURSING SALARIES				30,069	30,069	19
20	V	10a	THERAPY SALARIES				2,798	2,798	20
21	V	10a	REHAB SUPPLIES				885	885	21
22	V	17	ADMIN SALARIES				63,395	63,395	22
23	V	19	PROFESSIONAL FEES				5,150	5,150	23
24	V	20	ADVERTISING				2,072	2,072	24
25	V	21	OFFICE EXPENSE				15,852	15,852	25
26	V	21	OFFICE SALARIES				46,139	46,139	26
27	V	23	SEMINARS				1,039	1,039	27
28	V	24	TRAVEL				1,537	1,537	28
29	V	25	TRANSPORATION				6,003	6,003	29
30	V	26	INSURANCE				1,295	1,295	30
31	V	27	EMPLOYEE BENEFITS				42,857	42,857	31
32	V	30	DEPRECIATION				9,112	9,112	32
33	V	32	INTEREST				26,715	26,715	33
34	V	32	INTEREST TAG 18				2,823	2,823	34
35	V	32	INTEREST CP REHAB EQUIP				222	222	35
36	V	33	REAL ESTATE TAX TAG 18				4,156	4,156	36
37	V	35	EQUIPMENT RENT				6,109	6,109	37
38	V								38
39	Total			$			$ 273,099	$ * 273,099	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAKOB BAKST	DIR OPERATIONS			SEE ATTACHED	4.4		SALARY	$ 12,203	17-7	1
2	SHERWIN I. RAY	ADMIN CONSULT			SCHEDULES	4.4		SALARY	12,203	17-7	2
3	ROSLYN INDICH	CONTROLLER A/P				4.4		SALARY	3,656	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,062		13

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 [X] NO [ ]

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

Name of Related Organization: CAREPLUS MGMT
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	445,767	11	$ 100	$	32,967	$ 7	1
2	6	MAINT & REPAIRS	PATIENT DAYS	445,767	11	11,715		32,967	866	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	445,767	11	53,507	53,507	32,967	3,957	3
4	7	SECURITY	PATIENT DAYS	445,767	11	548		32,967	41	4
5	10	NURSING SALARIES	PATIENT DAYS	445,767	11	406,577	406,577	32,967	30,069	5
6	10a	THERAPY SALARIES	PATIENT DAYS	445,767	11	37,834	37,834	32,967	2,798	6
7	10a	REHAB SUPPLIES	PATIENT DAYS	445,767	11	11,963		32,967	885	7
8	17	ADMIN SALARIES	PATIENT DAYS	445,767	11	857,197	857,197	32,967	63,395	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	445,767	11	69,630		32,967	5,150	9
10	20	ADVERTISING	PATIENT DAYS	445,767	11	28,013		32,967	2,072	10
11	21	OFFICE EXPENSE	PATIENT DAYS	445,767	11	214,347		32,967	15,852	11
12	21	OFFICE SALARIES	PATIENT DAYS	445,767	11	623,871	623,871	32,967	46,139	12
13	23	SEMINARS	PATIENT DAYS	445,767	11	14,052		32,967	1,039	13
14	24	TRAVEL	PATIENT DAYS	445,767	11	20,788		32,967	1,537	14
15	25	TRANSPORATION	PATIENT DAYS	445,767	11	81,177		32,967	6,003	15
16	26	INSURANCE	PATIENT DAYS	445,767	11	17,511		32,967	1,295	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	445,767	11	579,494		32,967	42,857	17
18	30	DEPRECIATION	PATIENT DAYS	445,767	11	123,201		32,967	9,112	18
19	32	INTEREST	PATIENT DAYS	445,767	11	361,224		32,967	26,715	19
20	32	INTEREST TAG 18	PATIENT DAYS	445,767	11	38,177		32,967	2,823	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	445,767	11	3,007		32,967	222	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	445,767	11	56,199		32,967	4,156	22
23	35	EQUIPMENT RENT	PATIENT DAYS	445,767	11	82,599		32,967	6,109	23
24										24
25	TOTALS					$ 3,692,731	$ 1,978,986		$ 273,099	25

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	RELATED PARTY:ROSE GARDEN CENTER LLC						$	$			$	1
2	AMCORE BANK			MORTGAGE				2,857,340			265,220	2
3	CIB			CAPITAL IMPROV LOAN				1,312			600	3
4												4
5	RELATED PARTY										33,531	5
	Working Capital											
6	CAREPLUS MANAGEMENT	X		WORKING CAPITAL				719,434			61,508	6
7	SHAREHOLDERS	X		WORKING CAPITAL				1,610,400			49,538	7
8												8
9	TOTAL Facility Related						$	$ 5,188,486			$ 410,397	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							7,133	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,133	14
15	TOTALS (line 9+line14)						$	$ 5,188,486			$ 417,530	15

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

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.	$ 68,000	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.)	$ 50,735	2
3. Under or (over) accrual (line 2 minus line 1).	$ (17,265)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 52,000	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** $ 6,401 **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$ (6,401)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 28,334	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2002	58,259	8
2003	62,206	9
2004	64,334	10
2005	66,777	11
2006	50,735	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSE GARDEN CONVALESCENT CTR COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	NURSING HOME	$ 50,734.80	$ 50,734.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,734.80	$ 50,734.80

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1 NO BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	NURSING HOME	400,860	1998	$ 126,500	1
2					2
3	TOTALS	400,860		$ 126,500	3

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	110		1998		$ 2,536,069	$ 65,025	39	$ 65,025	$	$ 604,220	4
5					884,255	23,615	39	23,615		270,198	5
6											6
7											7
8	RELATED PARTY					1,895		1,895			8
	Improvement Type**										
9	CARE PLUS REHAB:										9
10	WATER HEATER			2004	10,051	257	39	257		1,253	10
11											11
12	SEWER LINE/FIRE RATED WALL			2005	16,205	589	27.5	589		1,447	12
13	TILE/CARPET			2005	2,583	94	27.5	94		232	13
14	SIDEWALKS			2006	3,700	247	15	247		371	14
15	SECURITY LOCKS/CAMERA SYSTEM			2006	11,010	400	27.5	400		584	15
16	GABLE WORK			2006	1,740	63	27.5	63		92	16
17	ROOFTOP AC & HEAT			2006	12,315	448	27.5	448		653	17
18	BATHROOM REMODEL			2006	2,950	107	27.5	107		156	18
19	ELECTRIC WORK			2006	2,575	94	27.5	94		137	19
20	THREE COMPARTMENT SINK & FAUCET			2006	2,000	73	27.5	73		106	20
21	TILE WORK IN KITCHEN			2006	6,862	250	27.5	250		365	21
22	GREASE TRAP			2007	3,900	65	27.5	65		65	22
23	ELECTRICAL WORK			2007	1,750	29	27.5	29		29	23
24	CABINETS/CLAY TILES			2007	1,793	30	27.5	30		30	24
25	EXHAUST WORK			2007	19,999	333	27.5	333		333	25
26	ANNUNCIATOR-NURSE STATION			2007	1,172	20	27.5	20		20	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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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)		$ 3,520,929	$ 93,634		$ 93,634	$	$ 880,291	70

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	$ 47,675	$ 3,608	$ 4,279	$ 671	10 YRS	$ 28,274	71
72	Current Year Purchases	36,294	7,259	1,815	(5,444)	10 YRS	1,815	72
73	Fully Depreciated Assets	1,024					1,024	73
74	RELATED PARTY		12,050	12,050				74
75	TOTALS	$ 84,993	$ 22,917	$ 18,144	$ (4,773)		$ 31,113	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,732,422	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,551	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,778	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,773)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 911,404	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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

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: _____ *

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.	/2008	$
13.	/2009	$
14.	/2010	$

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: $ 68,463 Description: SEE SCHEDULE ATTACHED
(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 ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	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	39-3	hrs	$		$ 45,536	$		$ 45,536	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,273			7,273	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			48,969			48,969	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				107,906		107,906	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					26,982			26,982	13
14	TOTAL			$		$ 128,760	$ 107,906		$ 236,666	14

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2007 (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	$ 3,995	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,936,530		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,094		6
7	Other Prepaid Expenses	36,730		7
8	Accounts Receivable (owners or related parties)	63,207		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,070,556	$	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	90,554		15
16	Equipment, at Historical Cost	86,163		16
17	Accumulated Depreciation (book methods)	(56,461)		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)**	$ 120,256	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,190,812	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 928,555	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	719,434		29
30	Accrued Salaries Payable	123,345		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,201		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable	388,249		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,228,784	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,804,318		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)**	$ 1,804,318	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,033,102	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,842,290)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,190,812	$	48

*(See instructions.)

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,610,737)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,610,737)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(231,553)	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)**	$ (231,553)	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)**	$ (1,842,290)	24 *

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,205,417	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,205,417	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	23,678	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 23,678	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,229,095	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	757,053	31
32	Health Care	1,778,550	32
33	General Administration	1,098,731	33
	B. Capital Expense		
34	Ownership	529,423	34
	C. Ancillary Expense		
35	Special Cost Centers	236,666	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,460,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	(231,553)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (231,553)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	1,905	2,151	$ 67,200	$ 31.24	1
2	Assistant Director of Nursing	1,832	2,410	56,165	23.30	2
3	Registered Nurses	8,786	10,191	231,365	22.70	3
4	Licensed Practical Nurses	14,706	16,040	405,201	25.26	4
5	CNAs & Orderlies	43,534	47,448	508,482	10.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,581	4,931	62,251	12.62	8
9	Activity Director	1,757	1,832	26,450	14.44	9
10	Activity Assistants	1,677	1,772	22,550	12.73	10
11	Social Service Workers	1,704	1,889	13,285	7.03	11
12	Dietician					12
13	Food Service Supervisor	2,202	2,410	38,304	15.89	13
14	Head Cook	5,457	5,852	45,180	7.72	14
15	Cook Helpers/Assistants	9,001	9,957	80,820	8.12	15
16	Dishwashers					16
17	Maintenance Workers	2,327	2,459	34,513	14.04	17
18	Housekeepers	9,997	10,703	88,229	8.24	18
19	Laundry	5,234	5,526	43,234	7.82	19
20	Administrator	2,032	2,089	78,048	37.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,928	6,462	126,186	19.53	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	1,880	2,081	13,223	6.35	31
32	Other Health Care(specify)	4,843	5,273	125,617	23.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,383	141,476	$ 2,066,303 *	$ 14.61	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	M	$ 8,336	1-3	35
36	Medical Director	O	7,000	9-3	36
37	Medical Records Consultant	N	1,046	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,045	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,190	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,417		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LOSENE FOOST	ADMINISTRATOR		$ 78,048
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,048

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 60,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 60,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		246,030
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 246,030

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,183
Unemployment Compensation Insurance	55,648
FICA Taxes	155,688
Employee Health Insurance	22,565
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,445
EMPLOYEE PHYSICAL EXAMS	525
PENSION/PROFIT SHARING PLANS	343
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 306,397

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,177
Health Care Worker Background Check	134
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	2,237
MARKETING/ADV/PROMO	20,039
LICENSES/DUES/SUBSCRIPTIONS	5,986
MGMT CO ALLOC	2,072
TRUST/FRANCHISE/CONTRIB/ETC	(2,237)
Less: Public Relations Expense	(0)
Non-allowable advertising	(20,039)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,369

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	630
MGMT CO ALLOC	1,537
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,167

**See instructions.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(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?

(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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,225**
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? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
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: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? ____ If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees