

		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: 0032805

Facility Name: Rosewood Care Center Galesburg

Address: 1250 West Carl Sandburg Drive Galesburg 61401
 Number City Zip Code

County: Knox

Telephone Number: (319) 344-5400 Fax # ()

HFS ID Number: 431375391001

Date of Initial License for Current Owners: 12/9/1987

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 7/1/06 to 6/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

(Signed) _____ (Date) _____

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	180	Skilled (SNF)	180	65,700	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	180	TOTALS	180	65,700	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			3,797	3,797	8
9	SNF/PED					9
10	ICF	22,967	9,090		32,057	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,967	9,090	3,797	35,854	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.57%

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 12/1/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/1987 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 32 and days of care provided 3,797

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	203,709	19,532	6,786	230,027		230,027	2,693	232,720		1
2	Food Purchase		164,314		164,314		164,314	(6,710)	157,604		2
3	Housekeeping	145,393	30,092		175,485		175,485		175,485		3
4	Laundry	54,589	13,538		68,127		68,127		68,127		4
5	Heat and Other Utilities			158,646	158,646		158,646	127	158,773		5
6	Maintenance	23,177	7,255	103,821	134,253		134,253	11,807	146,060		6
7	Other (specify):* Sanitation			14,091	14,091		14,091		14,091		7
8	TOTAL General Services	426,868	234,731	283,344	944,943		944,943	7,917	952,860		8
	B. Health Care and Programs										
9	Medical Director			9,594	9,594		9,594		9,594		9
10	Nursing and Medical Records	1,683,138	160,827	305,960	2,149,925		2,149,925		2,149,925		10
10a	Therapy	62,664	3,715	258,494	324,873		324,873	51,886	376,759		10a
11	Activities	45,866	2,871	2,400	51,137		51,137		51,137		11
12	Social Services	50,791		2,400	53,191		53,191		53,191		12
13	CNA Training										13
14	Program Transportation			251	251		251		251		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,842,459	167,413	579,099	2,588,971		2,588,971	51,886	2,640,857		16
	C. General Administration										
17	Administrative	73,914		148,500	222,414		222,414	(144,096)	78,318		17
18	Directors Fees										18
19	Professional Services			25,932	25,932		25,932	4,962	30,894		19
20	Dues, Fees, Subscriptions & Promotions			35,063	35,063		35,063	(8,156)	26,907		20
21	Clerical & General Office Expenses	143,439	22,747	15,868	182,054		182,054	144,656	326,710		21
22	Employee Benefits & Payroll Taxes			301,733	301,733		301,733	24,379	326,112		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,937	4,937		4,937	7,226	12,163		24
25	Other Admin. Staff Transportation			3,386	3,386		3,386	4,598	7,984		25
26	Insurance-Prop.Liab.Malpractice			73,800	73,800		73,800	9,633	83,433		26
27	Other (specify):*										27
28	TOTAL General Administration	217,353	22,747	609,219	849,319		849,319	43,202	892,521		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,486,680	424,891	1,471,662	4,383,233		4,383,233	103,005	4,486,238		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 Galesburg #0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			5,048	5,048	5,048	220,260	225,308			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						850,542	850,542			32
33	Real Estate Taxes			146,553	146,553	146,553		146,553			33
34	Rent-Facility & Grounds			1,024,080	1,024,080	1,024,080	(1,006,310)	17,770			34
35	Rent-Equipment & Vehicles			3,307	3,307	3,307		3,307			35
36	Other (specify):*										36
37	TOTAL Ownership			1,178,988	1,178,988	1,178,988	64,492	1,243,480			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		91,930	17,280	109,210	109,210		109,210			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			98,550	98,550	98,550		98,550			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		91,930	115,830	207,760	207,760		207,760			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,486,680	516,821	2,766,480	5,769,981	5,769,981	167,497	5,937,478			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 Galesburg

0032805

Report Period Beginning: 7/1/06

Ending: 6/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,504)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,616)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(206)	2		13
14	Non-Care Related Interest	(82,259)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(139)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,017)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,280)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,187)	20		28
29	Other-Attach Schedule Marketing Salary	(62,476)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (182,684)		\$	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)			34
35	Other- Attach Schedule	350,181	Var	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 350,181		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 167,497		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 Galesburg

ID# 0032805

Report Period Beginning: 7/1/06

Ending: 6/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (62,476)	21
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(62,476)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Galesburg

0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

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	2,693	0	0	0	0	0	0	0	0	2,693	1
2	Food Purchase	(6,710)	0	0	0	0	0	0	0	0	0	0	(6,710)	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	127	0	0	0	0	0	0	0	0	127	5
6	Maintenance	0	0	10,715	1,092	0	0	0	0	0	0	0	11,807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,710)	0	13,535	1,092	0	7,917	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	51,886	0	0	0	0	0	0	0	0	0	51,886	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	51,886	0	0	0	0	0	0	0	0	0	51,886	16
	C. General Administration													
17	Administrative	0	(148,500)	4,404	0	0	0	0	0	0	0	0	(144,096)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,017)	0	10,979	0	0	0	0	0	0	0	0	4,962	19
20	Fees, Subscriptions & Promotions	(11,467)	0	3,311	0	0	0	0	0	0	0	0	(8,156)	20
21	Clerical & General Office Expenses	(62,476)	0	207,128	4	0	0	0	0	0	0	0	144,656	21
22	Employee Benefits & Payroll Taxes	0	0	24,368	11	0	0	0	0	0	0	0	24,379	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(139)	0	7,357	8	0	0	0	0	0	0	0	7,226	24
25	Other Admin. Staff Transportation	0	0	4,583	15	0	0	0	0	0	0	0	4,598	25
26	Insurance-Prop.Liab.Malpractice	0	4,094	5,538	1	0	0	0	0	0	0	0	9,633	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(80,099)	(144,406)	267,668	39	0	43,202	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(86,809)	(92,520)	281,203	1,131	0	103,005	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	210,117	10,137	6	0	0	0	0	0	0	0	220,260	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(95,875)	946,417	0	0	0	0	0	0	0	0	0	850,542	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,024,080)	17,770	0	0	0	0	0	0	0	0	(1,006,310)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(95,875)	132,454	27,907	6	0	64,492	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)	(182,684)	39,934	309,110	1,137	0	167,497	45						

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	\$ 102,600	HSM Management Services, Inc		\$	(102,600)	1
2	V	17 Administration Fee	45,900	Midwest Administrative Services, Inc.			(45,900)	2
3	V							3
4	V	10a Therapy	258,494	Rosewood Therapy Services, Inc.		310,380	51,886	4
5	V							5
6	V	34 Rent	1,024,080	Galesburg Real Estate, Inc.			(1,024,080)	6
7	V	30 Depreciation		Galesburg Real Estate, Inc.		210,117	210,117	7
8	V	32 Interest		Galesburg Real Estate, Inc.		946,417	946,417	8
9	V	26 Property Insurance		Galesburg Real Estate, Inc.		4,094	4,094	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,431,074			\$ 1,471,008	\$ * 39,934	14

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

Facility Name & ID Number Rosewood Care Center Galesburg# 0032805Report Period Beginning: 7/1/06Ending: 6/30/07

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	6	See Schedule VIII	\$	HSM Management Services Inc.			\$ 415	\$ 415	15	
16	V	19	See Schedule VIII		HSM Management Services Inc.			168	168	16	
17	V	20	See Schedule VIII		HSM Management Services Inc.			70	70	17	
18	V	21	See Schedule VIII		HSM Management Services Inc.			78,379	78,379	18	
19	V	22	See Schedule VIII		HSM Management Services Inc.			9,437	9,437	19	
20	V	24	See Schedule VIII		HSM Management Services Inc.			5,659	5,659	20	
21	V	25	See Schedule VIII		HSM Management Services Inc.			2,587	2,587	21	
22	V	26	See Schedule VIII		HSM Management Services Inc.			993	993	22	
23	V									23	
24	V									24	
25	V	1	See Schedule VIII		Midwest Administrative Services, Inc.			2,693	2,693	25	
26	V	5	See Schedule VIII		Midwest Administrative Services, Inc.			127	127	26	
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.			10,300	10,300	27	
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.			4,404	4,404	28	
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.			10,811	10,811	29	
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.			3,241	3,241	30	
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.			128,749	128,749	31	
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.			14,931	14,931	32	
33	V	24	See Schedule VIII		Midwest Administrative Services, Inc.			1,698	1,698	33	
34	V	25	See Schedule VIII		Midwest Administrative Services, Inc.			1,996	1,996	34	
35	V	26	See Schedule VIII		Midwest Administrative Services, Inc.			4,545	4,545	35	
36	V	30	See Schedule VIII		Midwest Administrative Services, Inc.			10,137	10,137	36	
37	V	34	See Schedule VIII		Midwest Administrative Services, Inc.			17,770	17,770	37	
38	V									38	
39	Total			\$				\$ 309,110	\$ * 309,110	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 Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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		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	6	Repairs & Maintenance	\$ 209	Senior Living Services		\$ 1,301	\$ 1,092	15	
16	V	21	Clerical & Office Expenses		Senior Living Services		4	4	16	
17	V	22	Payroll Taxes & Emp Ben.		Senior Living Services		11	11	17	
18	V	24	Travel & Seminar		Senior Living Services		8	8	18	
19	V	25	Other Admin Staff Transportation		Senior Living Services		15	15	19	
20	V	26	Insurance		Senior Living Services		1	1	20	
21	V	30	Depreciation		Senior Living Services		6	6	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		\$ 209				\$ 1,346	\$ *	1,137	39

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

Facility Name & ID Number Rosewood Care Center Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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%	21,940	2	5.68%	Salary	\$ 1,320	17-8	1
2	Darrell Hoefling	Vice President	Management	25%	51,257	2	5.68%	Salary	3,084	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	\$ 4,404		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 Galesburg

0032805

Report Period Beginning:

7/1/06

Ending: 6/30/07

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	6	Maintenance	Total Cost	18	\$ 7,316	\$	4,896,845	\$ 415	1
2	19	Professional Services	Total Cost	18	2,959		4,896,845	168	2
3	20	Dues & Subscriptions	Total Cost	18	1,227		4,896,845	70	3
4	21	Salaries - Other	Total Cost	18	1,347,750	1,347,750	4,896,845	76,486	4
5	21	Taxes, Licenses, & Office Supplies	Total Cost	18	27,744		4,896,845	1,574	5
6	21	Telephone	Total Cost	18	5,615		4,896,845	319	6
7	22	Payroll Taxes	Total Cost	18	114,437		4,896,845	6,494	7
8	22	Employee Benefits	Total Cost	18	51,850		4,896,845	2,943	8
9	24	Travel & Seminar	Total Cost	18	99,709		4,896,845	5,659	9
10	25	Other Admin Staff Transp	Total Cost	18	45,582		4,896,845	2,587	10
11	26	Insurance	Total Cost	18	17,489		4,896,845	993	11
12	17	Direct - Admin	Direct Cost	1	0		1	0	12
13	17	Direct - Admin	Direct Cost	17	197,668	197,668	0	0	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,919,346	\$ 1,545,418		\$ 97,708	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

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	86,286,551	18	\$ 47,460	\$ 47,460	4,896,845	\$ 2,693	1
2	5	Utilities	Total Cost	86,286,551	18	2,240		4,896,845	127	2
3	6	Maintenance	Total Cost	86,286,551	18	181,498	40,614	4,896,845	10,300	3
4	17	Salaries - Officers	Total Cost	86,286,551	18	77,601	77,601	4,896,845	4,404	4
5	19	Professional Services	Total Cost	86,286,551	18	190,504		4,896,845	10,811	5
6	20	Dues & Subscriptions	Total Cost	86,286,551	18	57,105		4,896,845	3,241	6
7	21	Salaries - Other	Total Cost	86,286,551	18	1,779,601	1,779,601	4,896,845	100,994	7
8	21	Clerical & Office Supplies	Total Cost	86,286,551	18	489,073		4,896,845	27,755	8
9	22	Payroll Taxes & Emp Ben.	Total Cost	86,286,551	18	263,096		4,896,845	14,931	9
10	24	Travel & Seminar	Total Cost	86,286,551	18	29,921		4,896,845	1,698	10
11	25	Other Admin Transp	Total Cost	86,286,551	18	35,177		4,896,845	1,996	11
12	26	Insurance	Total Cost	86,286,551	18	80,079		4,896,845	4,545	12
13	30	Depreciation	Total Cost	86,286,551	18	155,885		4,896,845	8,847	13
14	34	Building Rent	Total Cost	86,286,551	18	313,115		4,896,845	17,770	14
15	17	Direct - Admin	Direct Cost	1	1			1		15
16	17	Direct - Admin	Direct Cost	17	17	105,112	105,112			16
17	30	Direct - Depreciation	Direct Cost	1	1	1,290		1	1,290	17
18	30	Direct - Depreciation	Direct Cost	17	17	20,220				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,828,977	\$ 2,050,388		\$ 211,402	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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Reliance Bank		X	Refinance Mortgage	Varies	5/3/05	\$ 10,957,000	\$ 10,957,000	5/2/08	7.2500	\$ 864,158	1
2	Less Interest Income Offset										(13,616)	2
3												3
4												4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 10,957,000	\$ 10,957,000			\$ 850,542	9
B. Non-Facility Related*												
10	Reliance Bank		X	Refinance Mortgage		5/3/05	1,043,000	1,043,000	5/2/08	7.2500	82,259	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 1,043,000	\$ 1,043,000			\$ 82,259	14
15	TOTALS (line 9+line14)						\$ 12,000,000	\$ 12,000,000			\$ 932,801	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Galesburg# 0032805 Report Period Beginning: 7/1/06Ending: 6/30/07

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.			\$	143,681	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.)			\$	142,492	2																				
3.	Under or (over) accrual (line 2 minus line 1).			\$	(1,189)	3																				
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	147,742	4																				
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																				
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																				
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	146,553	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:																										
	2002	123,540	8	<table border="1"> <thead> <tr> <th colspan="4">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>			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
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																							
	2003	133,650	9																							
	2004	138,659	10																							
	2005	142,258	11																							
	2006	142,726	12																							
2005 Payment = \$71,129																										
2006 Payment = \$71,363																										
Accrual = Balance of 2006 tax bill (\$71,363) + 1/2 of estimated 2007 tax bill (\$76,379)																										

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Rosewood Care Center Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0032805

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 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)	(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>99-04-251-012</u>	<u>Rosewood Sub Lots 2& 3</u>	\$ <u>142,725.74</u>	\$ <u>142,725.74</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>142,725.74</u>	\$ <u>142,725.74</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 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 Rosewood Care Center Galesburg

0032805 Report Period Beginning:

7/1/06 Ending:

6/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>5 acres</u>	<u>1987</u>	<u>\$ 85,594</u>	<u>1</u>
2		<u>6/90 Audit</u>		<u>(1,344)</u>	<u>2</u>
3	TOTALS	#VALUE!		\$ 84,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1987	\$ 2,304,765	\$	15-25	\$ 89,355	\$ 89,355	\$ 1,979,306	4
5	60			1998	2,243,326		25	89,733	89,733	785,164	5
6											6
7											7
8											8
	Improvement Type**										
9	6/90 Audit Adjustment			1987	6,600		25	264	264	4,224	9
10	18 Bed Addition			1989	27,565		15-25	600	600	23,365	10
11	Painting			1991	1,360		5			1,360	11
12	Painting			1992	1,520		5			1,520	12
13	Roof Vents			1992	6,896		25	276	276	4,208	13
14	Seeding/Landscaping/Berm			1988	32,414		25	1,296	1,296	24,420	14
15	Parking Lot Improvements			1992	5,673		25	227	227	3,386	15
16	Irrigation System			1994	7,253		10			7,253	16
17	Landscaping			1998	3,183		10	318	318	2,864	17
18	Facility Signage			1987	7,572		10			7,572	18
19	Hot Water Booster/Sinks			1987	4,606		10			4,606	19
20	Exhaust Hood & Fire Suppression System			1987	9,019		10			9,019	20
21	Carpet			1987	11,131		5			11,131	21
22	Nurse Call System & Paging System			1987	45,340		15			45,340	22
23	Nurse Call Addition			1988	1,643		10			1,643	23
24	Facility Signage			1991	5,133		10			5,133	24
25	Facility Signage			1992	1,000		10			1,000	25
26	Water Heaters			1992	3,123		10			3,123	26
27	Shingle Roof Replacement			2002	102,091		40	2,551	2,551	14,250	27
28	Seal & Restripe Parking Lot			2003	14,545		25	582	582	2,230	28
29	Repair Soffit & Facia on Gables			2003	5,394		40	135	135	483	29
30	Air Conditioning Unit & Heat Pumps			2003	9,817		10	982	982	3,648	30
31	Boiler			2003	20,269		10	2,027	2,027	7,263	31
32	Heat Pumps			2004	2,875		10	287	287	958	32
33	Paint Exterior of Building			2005	2,874		10	288	288	671	33
34	Fire Alarm Panel			2005	2,647		10	265	265	485	34
35	Console Heat Pumps			2006	6,337		10	634	634	792	35
36	Continued on next page										

*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 Galesburg

0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Canvas Awning	2007	\$ 3,067	\$	15	\$ 68	\$ 68	\$ 68	37
38	Seal and Stripe Parking Lot	2006	5,195		2	1,299	1,299	1,299	38
39									39
40									40
41									41
42	Leasehold Improvements - Facility:								42
43	Tiling/Dumpster Slabs/Guards/Painting	1993	20,103		7			20,103	43
44	Painting	1994	5,677		7			5,677	44
45	Painting/Base Stripping/Wallpaper/Carpet	1995	37,273		7			37,273	45
46	Wallpaper/Tiling/Painting	1996	10,392		7			10,392	46
47	Drapes/Sterling Textile/Fahlunds/Painting/Decorating	1998	15,318		7			15,318	47
48	Redline - Mat	1999	605		7			605	48
49	Computer Cabling	2000	2,895	414	7	414		2,723	49
50	Computer Cabling	2001	214	31	7	31		199	50
51	Wallpaper	2001	6,197	886	7	886		5,594	51
52	Dietary Door/Frame & Door	2002	5,105	730	7	730		4,194	52
53	Backflow Preventers/New Piping	2005	8,158	1,163	7	1,163		2,524	53
54	Painting	2005	3,855	550	7	550		1,101	54
55	Vinyl Wallcovering	2005	6,580	940	7	940		1,567	55
56	Painting	2005	3,951		7				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)		\$ 5,030,556	\$ 4,714		\$ 195,901	\$ 191,187	\$ 3,065,054	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 Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	\$ 351,736	\$ 334	\$ 21,578	\$ 21,244	5-10 Yrs	\$ 145,922	71
72	Current Year Purchases	41,645		3,429	3,429	5-10 Yrs	3,429	72
73	Fully Depreciated Assets	381,576					381,576	73
74								74
75	TOTALS	\$ 774,957	\$ 334	\$ 25,007	\$ 24,673		\$ 530,927	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	Midwest Admin. Services	Various	Various	\$ 19,040	\$	\$ 4,394	\$ 4,394	4 Yrs	\$ 5,017	76
77	Senior Living Services	Various	Various	27		6	6	4 Yrs	6	77
78										78
79										79
80	TOTALS			\$ 19,067	\$	\$ 4,400	\$ 4,400		\$ 5,023	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)	\$ 5,908,830	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,048	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 225,308	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 220,260	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,601,004	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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 Galesburg # 0032805 Report Period Beginning: 7/1/06 Ending: 6/30/07

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>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 Galesburg# 0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

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	\$	8,133	\$ 171,081	\$	8,133	\$ 171,081	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,756	58,877		1,756	58,877	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		7,904	80,422	3,715	7,904	84,137	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				82,063		82,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, X-Ray Other (specify): & Enterals	39-8				17,280	9,867		27,147	13
14	TOTAL			\$	17,793	\$ 327,660	\$ 95,645	17,793	\$ 423,305	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 Galesburg# 0032805Report Period Beginning: 7/1/06

Ending:

6/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/07

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,208,247)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>30,000</u>)	637,960		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,388		6
7	Other Prepaid Expenses	6,875		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (559,024)	\$	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	128,655		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(109,088)		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)	\$ 19,567	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (539,457)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 146,635	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,500		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,383		31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,742		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	17,200		35
	Other Current Liabilities(specify):			
36	<u>Accrued Management Fees</u>	(5)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 517,455	\$	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)	\$ 517,455	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,056,912)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (539,457)	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (224,513)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (224,513)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(832,399)	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)	\$ (832,399)	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)	\$ (1,056,912)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg# 0032805Report Period Beginning: 7/1/06Ending: 6/30/07**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	\$ 4,999,863	1
2	Discounts and Allowances for all Levels	(941,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,058,278	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	856,439	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 856,439	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	2,700	13
14	Non-Patient Meals	6,504	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)	\$ 9,204	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,616	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,616	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	45	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,937,582	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	944,943	31
32	Health Care	2,588,971	32
33	General Administration	849,319	33
B. Capital Expense			
34	Ownership	1,178,988	34
C. Ancillary Expense			
35	Special Cost Centers	109,210	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,769,981	40
41	Income before Income Taxes (line 30 minus line 40)**	(832,399)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (832,399)	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 Galesburg

0032805

Report Period Beginning:

7/1/06

Ending:

6/30/07

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	1,867	1,988	\$ 55,734	\$ 28.04	1
2	Assistant Director of Nursing	1,193	1,270	33,055	26.03	2
3	Registered Nurses	11,110	11,830	275,122	23.26	3
4	Licensed Practical Nurses	21,115	22,481	395,221	17.58	4
5	CNAs & Orderlies	84,910	90,405	858,775	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,841	5,154	62,664	12.16	8
9	Activity Director					9
10	Activity Assistants	4,947	5,267	45,866	8.71	10
11	Social Service Workers	4,051	4,313	50,791	11.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,869	22,219	203,709	9.17	15
16	Dishwashers					16
17	Maintenance Workers	2,090	2,226	23,177	10.41	17
18	Housekeepers	16,894	17,987	145,393	8.08	18
19	Laundry	5,421	5,772	54,589	9.46	19
20	Administrator	1,843	1,963	73,914	37.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,494	12,238	143,439	11.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,969	5,290	65,231	12.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,614	210,403	\$ 2,486,680 *	\$ 11.82	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	295	\$ 6,786	1-3	35
36	Medical Director	Contract	9,594	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	135	2,400	11-3	44
45	Social Service Consultant	135	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	565	\$ 21,180		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	646	\$ 26,718	10-3	50
51	Licensed Practical Nurses	7,056	250,122	10-3	51
52	Certified Nurse Assistants/Aides	1,387	29,120	10-3	52
53	TOTAL (lines 50 - 52)	9,089	\$ 305,960		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0032805

Report Period Beginning: 7/1/06

Ending: 6/30/07

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	
Sandy Kendrick	Administrator	0%	\$ 73,914	Workers' Compensation Insurance	\$ 66,625	IDPH License Fee	\$	
				Unemployment Compensation Insurance	36,934	Advertising: Employee Recruitment	5,586	
				FICA Taxes	189,232	Health Care Worker Background Check	2,270	
				Employee Health Insurance	1,662	(Indicate # of checks performed)		
				Employee Meals		Misc. Dues & Subscriptions	15,740	
				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	8,467	
				Tuition Reimbursement	1,210	Related Party Allocations	3,311	
				Employee Physicals	2,586			
				Employee Uniforms	563			
				Employee Relations	2,921	Less: Public Relations Expense	(4,073)	
				Related Party Allocations	24,379	Non-allowable advertising	(2,207)	
						Yellow page advertising	(2,187)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 73,914	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 326,112		\$ 26,907		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 102,600	Section Not Applicable			Out-of-State Travel	\$
Administrative Fees			45,900					
							In-State Travel	
							Lodging for regional supervisors	3,943
							Allocation of Home Office	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 148,500				Travel, Lodging & Seminars	7,365
(Attach a copy of any management service agreement)							Seminar Expense	855
C. Professional Services								
Vendor/Payee	Type		Amount					
See Attachment			\$					
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 12,163	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Rosewood Care Center Galesburg

Report Period Beginning: 7/1/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$9,936
- (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. \$ 51,738 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. \$ 98,550
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? N/A
- (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. \$ 6,504
- (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 \$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.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF GALESBURG INC.
IDPH ID #0032805
ATTACHMENT TO SCHEDULE XIX, Section C
6/30/2007

PROFESSIONAL SERVICES:

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
Azer III, P. C.	Medical Records Copy Fee	\$41
C. J. Schlosser & Co.	Accountant/Consultant	11,295
CT Corporation	Annual Reports	473
Daniel Maher	Legal	2,678
Drake, Narup & Mead, P.C.	Legal	86
Lowenbaum Parntership	Legal	6,468
Old Republic Surety Group	Surety Bond	50
Simeon Hunter & Stoerzbach Morrison, P.C.	Refund	(1,500)
Summers, Compton, Wells & Hamburg	Legal	114
Theresa Counts Burke	Legal	210
		<u>\$19,915</u>
Nonallowable Legal Fees		<u>6,017</u>
Total Schedule V, Line 19, Col. 3		<u><u>25,932</u></u>

ROSEWOOD CARE CENTER OF GALESBURG, INC.
IDPH ID #0032805
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2007

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 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. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC	MANAGEMENT CO.
MIDWEST ADMINISTRATIVE SERVICES, INC.	ADMINISTRATIVE CO.
GALESBURG 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

ROSEWOOD CARE CENTER OF GALESBURG
IDPH ID #0032805
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2007

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 3,386</u>
	<u><u>\$ 3,386</u></u>

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

ROSEWOOD CARE CENTER OF GALESBURG
IDPH ID #0032805
RECLASSIFICATIONS
6/30/2007

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(1,990)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	1,990	20