

		FOR BHF USE					

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**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:** 0036798

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

**Address:** 3401 Hennepin Drive Joliet 60435  
 Number City Zip Code

**County:** Will

**Telephone Number:** (815) 436-5900 Fax # ( )

**HFS ID Number:** 431478199001

**Date of Initial License for Current Owners:** 1/31/1991

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/06 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) \_\_\_\_\_

(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 of Joliet

# 0036798 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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>14,137</u>	<u>14,137</u>	8
9	SNF/PED					9
10	ICF	<u>3,132</u>	<u>17,075</u>		<u>20,207</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,132</u>	<u>17,075</u>	<u>14,137</u>	<u>34,344</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.41%

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 1/31/1991

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

YES  Date 1/31/1991 NO

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

YES  NO  If YES, enter number of beds certified 58 and days of care provided 14,137

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 of Joliet      #      0036798      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	
	<b>A. General Services</b>											
1	Dietary	202,873	22,728	8,938	234,539		234,539	2,886	237,425			1
2	Food Purchase		170,362		170,362		170,362	(6,778)	163,584			2
3	Housekeeping	123,179	31,068		154,247		154,247		154,247			3
4	Laundry	42,067	24,023		66,090		66,090		66,090			4
5	Heat and Other Utilities			150,298	150,298		150,298	136	150,434			5
6	Maintenance	22,920	8,448	182,246	213,614		213,614	(25,068)	188,546			6
7	Other (specify):* <b>Waste Collection</b>			10,789	10,789		10,789		10,789			7
8	<b>TOTAL General Services</b>	<b>391,039</b>	<b>256,629</b>	<b>352,271</b>	<b>999,939</b>		<b>999,939</b>	<b>(28,824)</b>	<b>971,115</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			10,313	10,313		10,313		10,313			9
10	Nursing and Medical Records	2,207,047	201,625	30,245	2,438,917		2,438,917		2,438,917			10
10a	Therapy	79,325	11,226	882,145	972,696		972,696	133,135	1,105,831			10a
11	Activities	66,861	4,815	817	72,493		72,493		72,493			11
12	Social Services	48,977	75	2,400	51,452		51,452		51,452			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,402,210</b>	<b>217,741</b>	<b>925,920</b>	<b>3,545,871</b>		<b>3,545,871</b>	<b>133,135</b>	<b>3,679,006</b>			16
	<b>C. General Administration</b>											
17	Administrative	94,787		604,000	698,787		698,787	(599,281)	99,506			17
18	Directors Fees											18
19	Professional Services			53,574	53,574		53,574	(1,385)	52,189			19
20	Dues, Fees, Subscriptions & Promotions			71,591	71,591		71,591	(38,406)	33,185			20
21	Clerical & General Office Expenses	146,397	28,992	9,342	184,731		184,731	165,045	349,776			21
22	Employee Benefits & Payroll Taxes			363,583	363,583		363,583	30,263	393,846			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,761	1,761		1,761	10,958	12,719			24
25	Other Admin. Staff Transportation			4,811	4,811		4,811	10,690	15,501			25
26	Insurance-Prop.Liab.Malpractice			51,097	51,097		51,097	10,584	61,681			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>241,184</b>	<b>28,992</b>	<b>1,159,759</b>	<b>1,429,935</b>		<b>1,429,935</b>	<b>(411,532)</b>	<b>1,018,403</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,034,433</b>	<b>503,362</b>	<b>2,437,950</b>	<b>5,975,745</b>		<b>5,975,745</b>	<b>(307,221)</b>	<b>5,668,524</b>			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of Joliet #0036798 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
	<b>D. Ownership</b>										
30	Depreciation			3,262	3,262	3,262	193,809	197,071			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						598,382	598,382			32
33	Real Estate Taxes			73,907	73,907	73,907	73,907	73,907			33
34	Rent-Facility & Grounds			1,536,928	1,536,928	1,536,928	(1,517,887)	19,041			34
35	Rent-Equipment & Vehicles			24,117	24,117	24,117		24,117			35
36	Other (specify):* <b>Mortgage Ins.</b>						70,146	70,146			36
37	<b>TOTAL Ownership</b>			1,638,214	1,638,214	1,638,214	(655,550)	982,664			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		427,270	66,913	494,183	494,183		494,183			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			65,700	65,700	65,700		65,700			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		427,270	132,613	559,883	559,883		559,883			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,034,433	930,632	4,208,777	8,173,842	8,173,842	(962,771)	7,211,071			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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	(6,359)	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	(19,255)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(419)	2		13
14	Non-Care Related Interest	(26,680)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,150)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,929)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,025)	20		28
29	Other-Attach Schedule Marketing Salary	(58,525)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (166,342)</b>		<b>\$</b>	<b>30</b>

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	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)	(796,429)	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (796,429)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (962,771)</b>		<b>37</b>

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Joliet

ID# 0036798

Report Period Beginning: 7/1/06

Ending: 6/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (58,525)	21
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49	<b>Total</b>	(58,525)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	2,886	0	0	0	0	0	0	0	0	2,886	1
2	Food Purchase	(6,778)	0	0	0	0	0	0	0	0	0	0	(6,778)	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	136	0	0	0	0	0	0	0	0	136	5
6	Maintenance	0	0	11,482	(36,550)	0	0	0	0	0	0	0	(25,068)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,778)</b>	<b>0</b>	<b>14,504</b>	<b>(36,550)</b>	<b>0</b>	<b>(28,824)</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	133,135	0	0	0	0	0	0	0	0	0	133,135	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>133,135</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>133,135</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(604,000)	4,719	0	0	0	0	0	0	0	0	(599,281)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,150)	0	11,765	0	0	0	0	0	0	0	0	(1,385)	19
20	Fees, Subscriptions & Promotions	(41,954)	0	3,548	0	0	0	0	0	0	0	0	(38,406)	20
21	Clerical & General Office Expenses	(58,525)	0	221,945	1,625	0	0	0	0	0	0	0	165,045	21
22	Employee Benefits & Payroll Taxes	0	0	26,111	4,152	0	0	0	0	0	0	0	30,263	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,883	3,075	0	0	0	0	0	0	0	10,958	24
25	Other Admin. Staff Transportation	0	0	4,911	5,779	0	0	0	0	0	0	0	10,690	25
26	Insurance-Prop.Liab.Malpractice	0	4,094	5,934	556	0	0	0	0	0	0	0	10,584	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(113,629)</b>	<b>(599,906)</b>	<b>286,816</b>	<b>15,187</b>	<b>0</b>	<b>(411,532)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(120,407)</b>	<b>(466,771)</b>	<b>301,320</b>	<b>(21,363)</b>	<b>0</b>	<b>(307,221)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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	180,770	10,859	2,180	0	0	0	0	0	0	0	193,809	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,935)	644,317	0	0	0	0	0	0	0	0	0	598,382	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,536,928)	19,041	0	0	0	0	0	0	0	0	(1,517,887)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	70,146	0	0	0	0	0	0	0	0	0	70,146	36
37	<b>TOTAL Ownership</b>	<b>(45,935)</b>	<b>(641,695)</b>	<b>29,900</b>	<b>2,180</b>	<b>0</b>	<b>(655,550)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(166,342)</b>	<b>(1,108,466)</b>	<b>331,220</b>	<b>(19,183)</b>	<b>0</b>	<b>(962,771)</b>	<b>45</b>						

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

Report Period Beginning:

7/1/06

Ending:

6/30/07

**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	See Attached List		See Attached List		
Darrell Hoefling	.25	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	0.00%	\$	\$ (102,600)	1
2	V	17 Administration Fee	501,400	Midwest Administrative Services, Inc.	0.00%		(501,400)	2
3	V							3
4	V	10a Therapy	882,145	Rosewood Therapy Services, Inc.	0.00%	1,015,280	133,135	4
5	V							5
6	V	34 Rent	1,536,928	Joliet Real Estate, Inc.	0.00%		(1,536,928)	6
7	V	30 Depreciation		Joliet Real Estate, Inc.	0.00%	180,770	180,770	7
8	V	32 Interest		Joliet Real Estate, Inc.	0.00%	644,317	644,317	8
9	V	36 Mortgage Insurance		Joliet Real Estate, Inc.	0.00%	70,146	70,146	9
10	V	26 Property Insurance		Joliet Real Estate, Inc.	0.00%	4,094	4,094	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,023,073			\$ 1,914,607	\$ * (1,108,466)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report 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.	0.00%	\$ 445	\$ 445	15		
16	V	19	See Schedule VIII		HSM Management Services Inc.	0.00%	180	180	16		
17	V	20	See Schedule VIII		HSM Management Services Inc.	0.00%	75	75	17		
18	V	21	See Schedule VIII		HSM Management Services Inc.	0.00%	83,985	83,985	18		
19	V	22	See Schedule VIII		HSM Management Services Inc.	0.00%	10,112	10,112	19		
20	V	24	See Schedule VIII		HSM Management Services Inc.	0.00%	6,063	6,063	20		
21	V	25	See Schedule VIII		HSM Management Services Inc.	0.00%	2,772	2,772	21		
22	V	26	See Schedule VIII		HSM Management Services Inc.	0.00%	1,064	1,064	22		
23	V								23		
24	V								24		
25	V	1	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	2,886	2,886	25		
26	V	5	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	136	136	26		
27	V	6	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	11,037	11,037	27		
28	V	17	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	4,719	4,719	28		
29	V	19	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	11,585	11,585	29		
30	V	20	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	3,473	3,473	30		
31	V	21	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	137,960	137,960	31		
32	V	22	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	15,999	15,999	32		
33	V	24	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	1,820	1,820	33		
34	V	25	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	2,139	2,139	34		
35	V	26	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	4,870	4,870	35		
36	V	30	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	10,859	10,859	36		
37	V	34	See Schedule VIII		Midwest Administrative Services, Inc.	0.00%	19,041	19,041	37		
38	V								38		
39	Total			\$			\$ 331,220	\$ * 331,220	39		

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 82,785	Senior Living Services		\$ 46,235	\$ (36,550)	15
16	V	21 Clerical & Office Expenses		Senior Living Services		1,625	1,625	16
17	V	22 Payroll Taxes & Emp Benefits		Senior Living Services		4,152	4,152	17
18	V	24 Travel & Seminar		Senior Living Services		3,075	3,075	18
19	V	25 Other Admin Staff Transportation		Senior Living Services		5,779	5,779	19
20	V	26 Insurance		Senior Living Services		556	556	20
21	V	30 Depreciation		Senior Living Services		2,180	2,180	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		\$ 82,785			\$ 63,602	\$ * (19,183)	39

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

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 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%	21,846	2	6.08	Salary	\$ 1,414	17-8	1
2	Darrell Hoefling	Vice President	Management	25%	51,036	2	6.08	Salary	3,305	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	\$ 4,719		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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	86,286,551	18	\$ 7,316	\$ 5,247,132	\$ 445	1
2	19	Professional Services	Total Cost	86,286,551	18	2,959	5,247,132	180	2
3	20	Dues & Subscriptions	Total Cost	86,286,551	18	1,227	5,247,132	75	3
4	21	Salaries - Other	Total Cost	86,286,551	18	1,347,750	1,347,750	81,957	4
5	21	Taxes, Licenses, & Office Supplies	Total Cost	86,286,551	18	27,744	5,247,132	1,687	5
6	21	Telephone	Total Cost	86,286,551	18	5,615	5,247,132	341	6
7	22	Payroll Taxes	Total Cost	86,286,551	18	114,437	5,247,132	6,959	7
8	22	Employee Benefits	Total Cost	86,286,551	18	51,850	5,247,132	3,153	8
9	24	Travel & Seminar	Total Cost	86,286,551	18	99,709	5,247,132	6,063	9
10	25	Other Admin Staff Transp	Total Cost	86,286,551	18	45,582	5,247,132	2,772	10
11	26	Insurance	Total Cost	86,286,551	18	17,489	5,247,132	1,064	11
12	17	Direct - Admin	Direct Cost	1	1	0	1	0	12
13	17	Direct - Admin	Direct Cost	17	17	197,668	197,668	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	\$ 104,696	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost	18	\$ 47,460	\$ 47,460	5,247,132	\$ 2,886	1
2	5	Utilities	Total Cost	18	2,240		5,247,132	136	2
3	6	Maintenance	Total Cost	18	181,498	40,614	5,247,132	11,037	3
4	17	Salaries - Officers	Total Cost	18	77,601	77,601	5,247,132	4,719	4
5	19	Professional Services	Total Cost	18	190,504		5,247,132	11,585	5
6	20	Dues & Subscriptions	Total Cost	18	57,105		5,247,132	3,473	6
7	21	Salaries - Other	Total Cost	18	1,779,601	1,779,601	5,247,132	108,219	7
8	21	Clerical & Office Supplies	Total Cost	18	489,073		5,247,132	29,741	8
9	22	Payroll Taxes & Emp Ben.	Total Cost	18	263,096		5,247,132	15,999	9
10	24	Travel & Semnar	Total Cost	18	29,921		5,247,132	1,820	10
11	25	Other Admin Transp	Total Cost	18	35,177		5,247,132	2,139	11
12	26	Insurance	Total Cost	18	80,079		5,247,132	4,870	12
13	30	Depreciation	Total Cost	18	155,885		5,247,132	9,479	13
14	34	Building Rent	Total Cost	18	313,115		5,247,132	19,041	14
15	17	Direct - Admin	Direct Cost	1			1		15
16	17	Direct - Admin	Direct Cost	17	105,112	105,112			16
17	30	Direct - Depreciation	Direct Cost	1	1,380		1	1,380	17
18	30	Direct - Depreciation	Direct Cost	17	20,130				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,828,977	\$ 2,050,388		\$ 226,524	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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Capmark		X	Refinance Mortgage	\$69,652.00	4/1/04	\$ 14,104,500	\$ 13,539,639	5/1/39	0.0450	\$ 613,876	1
2	Less: Interest Income										(19,255)	2
3	R.E. Company Interest Income										(2,017)	3
4	Amortization of Loan Costs										5,778	4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$69,652.00		\$ 14,104,500	\$ 13,539,639			\$ 598,382	9
	<b>B. Non-Facility Related*</b>											
10	Capmark		X	Refinance Mortgage			613,000	588,450	5/1/39	0.0450	26,680	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$ 613,000	\$ 588,450			\$ 26,680	14
15	<b>TOTALS (line 9+line14)</b>						\$ 14,717,500	\$ 14,128,089			\$ 625,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 70,146 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0036798

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>06-03-26-203-123-0000</u>	<u></u>	\$ <u>73,778.14</u>	\$ <u>73,778.14</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u>73,778.14</u>	\$ <u>73,778.14</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 of Joliet

# 0036798 Report Period Beginning:

7/1/06 Ending:

6/30/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,200 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>203,860</u>	<u>1990</u>	<u>\$ 213,780</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>203,860</b>		<b>\$ 213,780</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0036798

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120			1990	\$ 3,475,917	\$	25	\$ 139,037	\$ 139,037	\$ 2,363,627	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	General Requirements			1991	25,516		25	1,021	1,021	16,845	9
10	Developer Fee			1991	28,980		25	1,159	1,159	19,125	10
11	Construction Period Interest			1991	20,364		25	815	815	13,446	11
12	Arch and Eng Fees			1991	4,459		25	178	178	2,939	12
13	Storm Sewer			1991	32,675		25	1,307	1,307	21,566	13
14	Lawn Sprinkler			1991	10,990		25	440	440	7,258	14
15	Landscaping			1991	55,127		25	2,205	2,205	36,383	15
16	Mass Grading			1991	54,747		25	2,190	2,190	36,134	16
17	Asphalt Paving			1991	48,390		25	1,936	1,936	31,942	17
18	Sanitary Sewer			1991	8,069		25	323	323	5,329	18
19	Water Line			1991	15,500		25	620	620	10,230	19
20	Driveway and Sidewalks			1991	55,932		25	2,237	2,237	36,912	20
21	Walk-in Cooler Refrigerator			1991	6,888		20	344	344	5,678	21
22	Sink			1991	2,049		10			2,049	22
23	Exhaust and Air Hood			1991	4,670		10			4,670	23
24	Fire Exting. System			1991	1,647		10			1,647	24
25	Combo. Range/Hood			1991	3,925		10			3,925	25
26	Building Signage			1991	7,300		10 to 15			7,300	26
27	Generator/Accessories			1991	15,764		20	788	788	13,003	27
28	Cubicle Curtain Track			1991	6,176		10			6,176	28
29	6 Stainless Doors			1991	2,685		10			2,685	29
30	Monument Sign			1991	3,193		10			3,193	30
31	Wallcovering			1991	19,849		10			19,849	31
32	Carpeting			1991	9,585		10			9,585	32
33	Nurse Call Station			1991	28,217		20	1,411	1,411	23,281	33
34	Fire Alarm System			1991	15,724		20	786	786	12,970	34
35	Continued on Next Page										35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0036798

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	Door Bell	1991	\$ 1,026	\$	20	\$ 51	\$ 51	\$ 844	37
38	Door Alarm	1991	5,773		20	289	289	4,767	38
39	Public Address	1991	5,022		20	251	251	4,143	39
40	Cable	1991	15,712		20	786	786	12,967	40
41	Hot Water Boiler	1991	6,792		10			6,792	41
42	Hot Water Heater	1991	7,841		10			7,841	42
43	Load Bank Generator	1997	3,945		10	260	260	3,945	43
44	Seal & Stripe New Parking Spaces	2003	11,439		25	457	457	1,678	44
45	Roof Replacement	2005	6,944		10	694	694	1,389	45
46	Patient Rooms Sinks	2006	23,684		20	1,184	1,184	1,480	46
47	Water Softener	2005	5,116		10	512	512	895	47
48	Backflow Device	2005	8,892		20	445	445	741	48
49	Backflow Device for Water Heater	2005	1,984		20	99	99	165	49
50	Door Closers	2005	5,496		15	366	366	580	50
51	Satellite System	2006	9,002		10	600	600	600	51
52	Seal & Patch Parking Lot	2006	5,055		2	1,685	1,685	1,685	52
53									53
54	Leashold Improvements - Facility:								54
55	Painting/Baseboards/Tilings	1995	14,902		7			14,902	55
56	Carpeting	1996	4,157		7			4,157	56
57	Floor Drain	1997	1,604		7			1,604	57
58	Entry Floor Mat	1999	1,213		7			1,213	58
59	Ceiling Tiles	1999	1,820		7			1,820	59
60	Plants	1999	2,441		7			2,441	60
61	Wallpaper/Wallpaper Install/Blinds	1999	14,251		7			14,251	61
62	Air System	1999	13,860		7			13,860	62
63	Carpeting	1999	14,300	510	7	510		14,300	63
64	Computer Cabling	2000	2,392	342	7	342		2,250	64
65	Vinyl Tile	2005	10,670	1,524	7	1,524		3,811	65
66	Wallpapering	2005	3,095	442	7	442		774	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,172,766	\$ 2,818		\$ 167,294	\$ 164,476	\$ 2,843,642	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 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	\$ 223,533	\$ 444	\$ 21,935	\$ 21,491	5-15 yrs	\$ 134,253	71
72	Current Year Purchases	17,080		954	954	5-15 yrs	954	72
73	Fully Depreciated Assets	512,079					512,079	73
74								74
75	TOTALS	\$ 752,692	\$ 444	\$ 22,889	\$ 22,445		\$ 647,286	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	\$ 20,402	\$	\$ 4,708	\$ 4,708	4 yrs	\$ 5,376	76
77	Senior Living Services	Various	Various	10,474		2,180	2,180	4 yrs	2,511	77
78										78
79										79
80	TOTALS			\$ 30,876	\$	\$ 6,888	\$ 6,888		\$ 7,887	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)	\$ 5,170,114	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,262	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,071	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 193,809	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,498,815	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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12.	_____ /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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 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)	
<b>TOTAL TRAINED</b>	

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

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

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798

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	\$	31,550	\$ 535,144	\$	31,550	\$ 535,144	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		963	15,224		963	15,224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		27,877	464,912	11,226	27,877	476,138	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				412,208		412,208	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): <u>and Enterals</u>	39-8				66,913	15,062		81,975	13
14	TOTAL			\$	60,390	\$ 1,082,193	\$ 438,496	60,390	\$ 1,520,689	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report 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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 731,821	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>105,000</u> )	1,017,407		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	636		6
7	Other Prepaid Expenses	5,146		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,755,010	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	96,679		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(86,671)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,008	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,765,018	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 221,620	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,722		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,675		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,606		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,100		35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Fees - Related Parties</u>	107,503		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 596,226	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 596,226	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,168,792	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,765,018	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 377,908	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 377,908	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,034,884	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	(244,000)	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)	\$ 790,884	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,168,792	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,871,890	1
2	Discounts and Allowances for all Levels	(3,827,726)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,044,164</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,131,976	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,131,976</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,900	13
14	Non-Patient Meals	6,359	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 10,259</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	19,255	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 19,255</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	3,072	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,072</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 9,208,726</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	999,939	31
32	Health Care	3,545,871	32
33	General Administration	1,429,935	33
<b>B. Capital Expense</b>			
34	Ownership	1,638,214	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	494,183	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,173,842</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,034,884</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,034,884</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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	1,969	2,082	\$ 65,981	\$ 31.69	1
2	Assistant Director of Nursing	1,185	1,253	34,989	27.92	2
3	Registered Nurses	28,376	30,006	803,548	26.78	3
4	Licensed Practical Nurses	20,893	22,093	486,951	22.04	4
5	CNAs & Orderlies	67,631	71,515	735,175	10.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,416	5,727	79,325	13.85	8
9	Activity Director					9
10	Activity Assistants	5,530	5,848	66,861	11.43	10
11	Social Service Workers	3,667	3,878	48,977	12.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,215	19,261	202,873	10.53	15
16	Dishwashers					16
17	Maintenance Workers	2,038	2,155	22,920	10.64	17
18	Housekeepers	14,193	15,008	123,179	8.21	18
19	Laundry	5,406	5,717	42,067	7.36	19
20	Administrator	2,050	2,168	94,787	43.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,722	13,453	146,397	10.88	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	5,027	5,316	80,403	15.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,318	205,480	\$ 3,034,433 *	\$ 14.77	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		\$ 8,938	1-3	35
36	Medical Director	Contract	10,313	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	40	817	11-3	44
45	Social Service Consultant	144	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	\$ 22,468		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	150	\$ 8,964	10-3	50
51	Licensed Practical Nurses	387	18,778	10-3	51
52	Certified Nurse Assistants/Aides	115	2,503	10-3	52
53	TOTAL (lines 50 - 52)	652	\$ 30,245		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

# 0036798

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		
Bill Matjasich	Administrator	0	\$ 94,787	Workers' Compensation Insurance	\$ 80,709	IDPH License Fee	\$		
				Unemployment Compensation Insurance	45,533	Advertising: Employee Recruitment	12,667		
				FICA Taxes	231,053	Health Care Worker Background Check	7,890		
				Employee Health Insurance	1,635	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues and Subscriptions	9,081		
				Employee Physicals	1,423	Promotional Advertising	38,953		
				Employee Uniforms	623	Related Party Allocations	3,548		
				Employee Relations	2,607				
				Related Party Allocations	30,263				
						Less: Public Relations Expense	(33,039)		
						Non-allowable advertising	(890)		
						Yellow page advertising	(5,025)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
			\$ 94,787		\$ 393,846		\$ 33,185		
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 N/A		\$	Out-of-State Travel	\$	
Administrative Fees			501,400						
							In-State Travel		
							Allocation of home office travel costs	10,958	
							Seminar Expense	1,761	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				(agree to Sch. V, line 24, col. 8)	
			\$ 604,000			\$		\$ 12,719	
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attachment			\$						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
			\$						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Rosewood Care Center of Joliet

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

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association - \$6,624
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,087 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,359
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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 JOLIET INC.  
IDPH ID #0036798  
ATTACHMENT TO SCHEDULE XIX, Section C  
6/30/2007

**PROFESSIONAL SERVICES:**

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
Alholm, Monahan, Klauke, Hay & Oldenburg	Legal	\$44,612
C. J. Schlosser & Co.	Accountant/Consultant	4,200
CT Corporation	Annual Reports	473
Daniel Maher	Legal	1,637
Kutak Rock LLP	Legal	311
Insurance Reimbursement		(11,825)
Old Republic Surety Group	Surety Bond	50
Summers, Compton, Wells & Hamburg	Legal	321
Theresa Counts Burke	Legal	645
Total		40,424
Nonallowable Legal Fees		13,150
Total Schedule V, Line 19, Col. 3		<u>\$ 53,574</u>

ROSEWOOD CARE CENTER OF JOLIET, INC.  
IDPH ID #0036798  
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 GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, 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.
JOLIET REAL ESTATE HOLDING COMPANY, 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 JOLIET, INC.  
IDPH ID #0036798  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2007

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 4,811</u>
	<u><u>\$ 4,811</u></u>

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