



Facility Name & ID Number Rosewood Care Center St Charles

# 0041764 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	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			6,290	6,290	8
9	SNF/PED					9
10	ICF	6,918	14,389		21,307	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,918	14,389	6,290	27,597	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.37%

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

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

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

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

None

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

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

YES  NO

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

YES  NO

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

Date started 6/28/1999

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

YES  Date 6/28/1999 NO

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

YES  NO  If YES, enter number of beds certified 38 and days of care provided 6,290

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 St Charles # 0041764 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	190,820	18,926	8,087	217,833		217,833	2,944	220,777		1
2	Food Purchase		146,591		146,591		146,591	(923)	145,668		2
3	Housekeeping	110,986	24,712		135,698		135,698		135,698		3
4	Laundry	28,165	9,947		38,112		38,112		38,112		4
5	Heat and Other Utilities			116,612	116,612		116,612	139	116,751		5
6	Maintenance	33,923	19,074	196,301	249,298		249,298	(28,298)	221,000		6
7	Other (specify):* Sanitation Services			8,159	8,159		8,159		8,159		7
8	<b>TOTAL General Services</b>	<b>363,894</b>	<b>219,250</b>	<b>329,159</b>	<b>912,303</b>		<b>912,303</b>	<b>(26,138)</b>	<b>886,165</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	1,563,924	169,946	543,838	2,277,708		2,277,708		2,277,708		10
10a	Therapy	55,433	3,077	365,144	423,654		423,654	28,125	451,779		10a
11	Activities	63,695	4,334	392	68,421		68,421		68,421		11
12	Social Services	33,312		3,470	36,782		36,782		36,782		12
13	CNA Training										13
14	Program Transportation			26	26		26		26		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,716,364</b>	<b>177,357</b>	<b>920,370</b>	<b>2,814,091</b>		<b>2,814,091</b>	<b>28,125</b>	<b>2,842,216</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	50,472		120,990	171,462		171,462	(108,421)	63,041		17
18	Directors Fees										18
19	Professional Services			49,609	49,609		49,609	4,218	53,827		19
20	Dues, Fees, Subscriptions & Promotions			70,327	70,327	1,990	72,317	(39,220)	33,097		20
21	Clerical & General Office Expenses	173,236	26,030	22,359	221,625		221,625	158,870	380,495		21
22	Employee Benefits & Payroll Taxes			289,122	289,122		289,122	31,421	320,543		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,608	2,608	(1,990)	618	11,330	11,948		24
25	Other Admin. Staff Transportation			13,197	13,197		13,197	11,669	24,866		25
26	Insurance-Prop.Liab.Malpractice			57,311	57,311		57,311	10,788	68,099		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>223,708</b>	<b>26,030</b>	<b>625,523</b>	<b>875,261</b>		<b>875,261</b>	<b>80,655</b>	<b>955,916</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,303,966</b>	<b>422,637</b>	<b>1,875,052</b>	<b>4,601,655</b>		<b>4,601,655</b>	<b>82,642</b>	<b>4,684,297</b>		<b>29</b>

\*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 St Charles

#0041764

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			2,779	2,779	2,779	223,765	226,544				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						404,206	404,206				32
33	Real Estate Taxes			138,465	138,465	138,465		138,465				33
34	Rent-Facility & Grounds			1,034,606	1,034,606	1,034,606	(1,015,182)	19,424				34
35	Rent-Equipment & Vehicles			15,966	15,966	15,966		15,966				35
36	Other (specify):* <b>Mortgage Insurance</b>						63,063	63,063				36
37	<b>TOTAL Ownership</b>			1,191,816	1,191,816	1,191,816	(324,148)	867,668				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,175	42,830	245,005	245,005		245,005				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678	59,678		59,678				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		202,175	102,508	304,683	304,683		304,683				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,303,966	624,812	3,169,376	6,098,154	6,098,154	(241,506)	5,856,648				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 St Charles

# 0041764

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	(545)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,737)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(14,942)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(378)	2		13
14	Non-Care Related Interest	(183,317)	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	(255)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,784)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(35,672)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,166)	20		28
29	Other-Attach Schedule Marketing Salary	(64,675)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (319,471)		\$	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)	77,965	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 77,965		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (241,506)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center St Charles

ID# 0041764

Report Period Beginning: 7/1/06

Ending: 6/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (64,675)	21
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49	<b>Total</b>	(64,675)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rosewood Care Center St Charles

# 0041764

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	2,944	0	0	0	0	0	0	0	0	2,944	1
2	Food Purchase	(923)	0	0	0	0	0	0	0	0	0	0	(923)	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	139	0	0	0	0	0	0	0	0	139	5
6	Maintenance	0	0	11,713	(40,011)	0	0	0	0	0	0	0	(28,298)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(923)</b>	<b>0</b>	<b>14,796</b>	<b>(40,011)</b>	<b>0</b>	<b>(26,138)</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	28,125	0	0	0	0	0	0	0	0	0	28,125	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>28,125</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>28,125</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(120,990)	12,569	0	0	0	0	0	0	0	0	(108,421)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,784)	0	12,002	0	0	0	0	0	0	0	0	4,218	19
20	Fees, Subscriptions & Promotions	(42,838)	0	3,618	0	0	0	0	0	0	0	0	(39,220)	20
21	Clerical & General Office Expenses	(69,412)	0	226,409	1,873	0	0	0	0	0	0	0	158,870	21
22	Employee Benefits & Payroll Taxes	0	0	26,636	4,785	0	0	0	0	0	0	0	31,421	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(255)	0	8,041	3,544	0	0	0	0	0	0	0	11,330	24
25	Other Admin. Staff Transportation	0	0	5,010	6,659	0	0	0	0	0	0	0	11,669	25
26	Insurance-Prop.Liab.Malpractice	0	4,094	6,053	641	0	0	0	0	0	0	0	10,788	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(120,289)</b>	<b>(116,896)</b>	<b>300,338</b>	<b>17,502</b>	<b>0</b>	<b>80,655</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(121,212)</b>	<b>(88,771)</b>	<b>315,134</b>	<b>(22,509)</b>	<b>0</b>	<b>82,642</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center St Charles # 0041764 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	210,452	10,800	2,513	0	0	0	0	0	0	0	223,765	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(198,259)	602,465	0	0	0	0	0	0	0	0	0	404,206	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,034,606)	19,424	0	0	0	0	0	0	0	0	(1,015,182)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	63,063	0	0	0	0	0	0	0	0	0	63,063	36
37	<b>TOTAL Ownership</b>	<b>(198,259)</b>	<b>(158,626)</b>	<b>30,224</b>	<b>2,513</b>	<b>0</b>	<b>(324,148)</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>(319,471)</b>	<b>(247,397)</b>	<b>345,358</b>	<b>(19,996)</b>	<b>0</b>	<b>(241,506)</b>	<b>45</b>						

Facility Name & ID Number Rosewood Care Center St Charles

# 0041764

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	\$ 93,195	HSM Management Services, Inc	0.00%	\$	\$(93,195)
2	V	17 Administration Fee	27,795	Midwest Administrative Services, Inc.	0.00%		(27,795)
3	V						
4	V	10a Therapy	365,144	Rosewood Therapy Services, Inc.	0.00%	393,269	28,125
5	V						
6	V	34 Rent	1,034,606	St. Charles Real Estate, Inc.	0.00%		(1,034,606)
7	V	30 Depreciation		St. Charles Real Estate, Inc.	0.00%	210,452	210,452
8	V	32 Interest		St. Charles Real Estate, Inc.	0.00%	602,465	602,465
9	V	36 Mortgage Insurance		St. Charles Real Estate, Inc.	0.00%	63,063	63,063
10	V	26 Property Insurance		St. Charles Real Estate, Inc.	0.00%	4,094	4,094
11	V						
12	V						
13	V						
14	Total		\$ 1,520,740			\$ 1,273,343	\$ * (247,397)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles# 0041764Report 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	5 Cost to Related Organization	6	7	8 Difference:		
		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	See Schedule VIII	\$		454	\$	454	15
16	V	17	See Schedule VIII			7,755		7,755	16
17	V	19	See Schedule VIII			184		184	17
18	V	20	See Schedule VIII			76		76	18
19	V	21	See Schedule VIII			85,675		85,675	19
20	V	22	See Schedule VIII			10,315		10,315	20
21	V	24	See Schedule VIII			6,185		6,185	21
22	V	25	See Schedule VIII			2,828		2,828	22
23	V	26	See Schedule VIII			1,085		1,085	23
24	V								24
25	V	1	See Schedule VIII			2,944		2,944	25
26	V	5	See Schedule VIII			139		139	26
27	V	6	See Schedule VIII			11,259		11,259	27
28	V	17	See Schedule VIII			4,814		4,814	28
29	V	19	See Schedule VIII			11,818		11,818	29
30	V	20	See Schedule VIII			3,542		3,542	30
31	V	21	See Schedule VIII			140,734		140,734	31
32	V	22	See Schedule VIII			16,321		16,321	32
33	V	24	See Schedule VIII			1,856		1,856	33
34	V	25	See Schedule VIII			2,182		2,182	34
35	V	26	See Schedule VIII			4,968		4,968	35
36	V	30	See Schedule VIII			10,800		10,800	36
37	V	34	See Schedule VIII			19,424		19,424	37
38	V								38
39	Total			\$		345,358	\$	* 345,358	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	\$ 95,397	Senior Living Services	0.00%	\$ 55,386	\$ (40,011)	15
16	V	21 Clerical & Office Expenses		Senior Living Services	0.00%	1,873	1,873	16
17	V	22 Payroll Taxes & Emp Benefits		Senior Living Services	0.00%	4,785	4,785	17
18	V	24 Travel & Seminar		Senior Living Services	0.00%	3,544	3,544	18
19	V	25 Other Admin Staff Transportation		Senior Living Services	0.00%	6,659	6,659	19
20	V	26 Insurance		Senior Living Services	0.00%	641	641	20
21	V	30 Depreciation		Senior Living Services	0.00%	2,513	2,513	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		\$ 95,397			\$ 75,401	\$ * (19,996)	39

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

Facility Name & ID Number Rosewood Care Center St Charles # 0041764 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%	21,818	2	6.20%	Salary	\$ 1,443	17-8	1
2	Darrell Hoefling	Vice President	Management	25%	50,970	2	6.20%	Salary	3,371	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	\$ 4,814		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 St Charles

# 0041764

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	\$	5,352,658	\$ 454	1
2	19	Professional Services	Total Cost	18	2,959		5,352,658	184	2
3	20	Dues & Subscriptions	Total Cost	18	1,227		5,352,658	76	3
4	21	Salaries - Other	Total Cost	18	1,347,750	1,347,750	5,352,658	83,606	4
5	21	Taxes, Licenses, & Office Supplies	Total Cost	18	27,744		5,352,658	1,721	5
6	21	Telephone	Total Cost	18	5,615		5,352,658	348	6
7	22	Payroll Taxes	Total Cost	18	114,437		5,352,658	7,099	7
8	22	Employee Benefits	Total Cost	18	51,850		5,352,658	3,216	8
9	24	Travel & Seminar	Total Cost	18	99,709		5,352,658	6,185	9
10	25	Other Admin Staff Transp	Total Cost	18	45,582		5,352,658	2,828	10
11	26	Insurance	Total Cost	18	17,489		5,352,658	1,085	11
12	17	Direct - Admin	Direct Cost	1	7,755	7,755	1	7,755	12
13	17	Direct - Admin	Direct Cost	17	189,913	189,913	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		\$ 114,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

# 0041764

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	18	\$ 47,460	\$ 47,460	5,352,658	\$ 2,944	1
2	5	Utilities	Total Cost	18	2,240		5,352,658	139	2
3	6	Maintenance	Total Cost	18	181,498	40,614	5,352,658	11,259	3
4	17	Salaries - Officers	Total Cost	18	77,601	77,601	5,352,658	4,814	4
5	19	Professional Services	Total Cost	18	190,504		5,352,658	11,818	5
6	20	Dues & Subscriptions	Total Cost	18	57,105		5,352,658	3,542	6
7	21	Salaries - Others	Total Cost	18	1,779,601	1,779,601	5,352,658	110,395	7
8	21	Clerical & Office Supplies	Total Cost	18	489,073		5,352,658	30,339	8
9	22	Payroll Taxes & Emp Ben	Total Cost	18	263,096		5,352,658	16,321	9
10	24	Travel & Seminar	Total Cost	18	29,921		5,352,658	1,856	10
11	25	Other Admin Transp	Total Cost	18	35,177		5,352,658	2,182	11
12	26	Insurance	Total Cost	18	80,079		5,352,658	4,968	12
13	30	Depreciation	Total Cost	18	155,885		5,352,658	9,670	13
14	34	Building Rent	Total Cost	18	313,115		5,352,658	19,424	14
15	30	Direct - Depreciation	Direct Cost	1			1		15
16	30	Direct - Depreciation	Direct Cost	17	105,112	105,112			16
17	6	Direct - Maintenance	Direct Cost	1	1,130		1	1,130	17
18	6	Direct - Maintenance	Direct Cost	17	20,380				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,828,977	\$ 2,050,388		\$ 230,801	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Capmark		X	Refinance Mortgage	\$63,582.00	11/1/04	\$ 9,101,649	\$ 8,819,502	12/1/39	0.0469	\$ 416,533	1								
2	Less: Interest Income										(14,942)	2								
3	R.E. Company Interest Income										(2,456)	3								
4	Amortization of Loan Costs										5,071	4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$63,582.00		\$ 9,101,649	\$ 8,819,502			\$ 404,206	9								
<b>B. Non-Facility Related*</b>																				
10	Capmark		X	Refinance Mortgage		11/1/04	4,005,651	3,881,477	12/1/39	0.0469	183,317	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$ 4,005,651	\$ 3,881,477			\$ 183,317	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 13,107,300	\$ 12,700,979			\$ 587,523	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,063 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.)

Facility Name & ID Number Rosewood Care Center St Charles# 0041764 Report Period Beginning: 7/1/06Ending: 6/30/07

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>146,087</b>	<b>1</b>
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.)			\$	<b>142,595</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(3,492)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>141,957</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>138,465</b>	<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>94,952</u>	<u>8</u>			
2003	<u>100,920</u>	<u>9</u>			
2004	<u>102,696</u>	<u>10</u>			
2005	<u>144,641</u>	<u>11</u>			
2006	<u>140,551</u>	<u>12</u>			
<u>2005 Payment = \$72,320</u>					
<u>2006 Payment = \$70,275</u>					
<u>Accrual = Balance of 2006 tax bill (\$70,276) + 1/2 of estimated 2007 tax bill (\$71,681)</u>					
			<b>FOR BHF USE ONLY</b>		
			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006 \$	<b>13</b>
			<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
			<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
			<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

## 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 St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0041764

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

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

Enter the tax index number and real estate tax assessed for 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>09-26-226-008</u>	<u></u>	\$ <u>140,551.20</u>	\$ <u>140,551.20</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>140,551.20</u>	\$ <u>140,551.20</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 St Charles

# 0041764 Report Period Beginning:

7/1/06 Ending:

6/30/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 1

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

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>8.35 acres</u>	<u>1994</u>	<u>\$ 1,714,398</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 1,714,398</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

# 0041764

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	109			1999	\$ 5,353,402	\$	40	\$ 133,835	\$ 133,835	\$ 1,070,680	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Site Development			1999	555,639		25	22,226	22,226	177,807	9
10	Automatic Doors			2002	12,016		10	1,202	1,202	6,611	10
11	Convert Private Rooms to Semi-Private			2002	95,679		40	2,392	2,392	13,156	11
12	Seal & Stripe Parking Lot			2004	6,024		2	1,004	1,004	6,024	12
13	Water Softener			2005	8,323		10	832	832	1,595	13
14	Heat Exchanger for Boiler			2006	3,573		10	357	357	506	14
15	Heat Pumps			2006	6,894		10	689	689	919	15
16	Heat Exchanger			2006	3,764		10	376	376	501	16
17	Compressors			2006	6,919		10	634	634	634	17
18	Flue Repiping			2006	5,075		10	465	465	465	18
19											19
20											20
21	Facility Leaseholds:										21
22	Computer Cabling			2001	2,895	414	7	414		2,688	22
23	Vinyl Tile Flooring			2003	6,300	900	7	900		3,450	23
24	Painting & Decorating			2004	2,662	380	7	380		1,014	24
25	Vinyl Tile Flooring			2004	2,713	388	7	388		1,034	25
26	Drywall/Wallcovering			2005	4,880	697	7	697		1,336	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

# 0041764

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 6,076,758	\$ 2,779		\$ 166,791	\$ 164,012	\$ 1,288,420	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 St Charles # 0041764 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	\$ 483,584	\$	\$ 51,089	\$ 51,089	10 years	\$ 354,161	71
72	Current Year Purchases	11,204		1,348	1,348	10 years	1,348	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 494,788	\$	\$ 52,437	\$ 52,437		\$ 355,509	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	\$ 20,813	\$	\$ 4,803	\$ 4,803	4 Years	\$ 5,484	76
77	Senior Living Services	Various	Various	12,069		2,513	2,513	4 Years	2,893	77
78										78
79										79
80	TOTALS			\$ 32,882	\$	\$ 7,316	\$ 7,316		\$ 8,377	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,318,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,779	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 226,544	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 223,765	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,652,306	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 St Charles # 0041764 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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	12,138	\$ 224,532	\$	12,138	\$ 224,532	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,555	44,688		1,555	44,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		11,999	124,049	3,077	11,999	127,126	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				175,888		175,888	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>Enterals</u>	39-8				42,831	26,287		69,118	13
14	<b>TOTAL</b>			\$	25,692	\$ 436,100	\$ 205,252	25,692	\$ 641,352	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 St Charles# 0041764Report 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	\$ (599,274)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u> )	743,712		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,655		6
7	Other Prepaid Expenses	5,013		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>	\$ 157,106	\$	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	19,450		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(9,522)		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>	\$ 9,928	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 167,034	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 206,131	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,790		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,121		31
32	Accrued Real Estate Taxes(Sch.IX-B)	141,957		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,900		35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expense - RP</u>	(58,198)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 431,701	\$	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>	\$ 431,701	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (264,667)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 167,034	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (269,629)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (269,629)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	4,962	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 4,962</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (264,667)</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles# 0041764Report 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	\$ 6,369,734	1
2	Discounts and Allowances for all Levels	(1,591,577)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,778,157	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,300,701	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,300,701	8
<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	545	14
15	Telephone, Television and Radio	4,737	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>	\$ 9,182	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,942	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,942	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	134	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 134	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,103,116	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	912,303	31
32	Health Care	2,814,091	32
33	General Administration	875,261	33
<b>B. Capital Expense</b>			
34	Ownership	1,191,816	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	245,005	35
36	Provider Participation Fee	59,678	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,098,154	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	4,962	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 4,962	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 St Charles

# 0041764

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	1,291	1,359	\$ 46,327	\$ 34.09	1
2	Assistant Director of Nursing	2,012	2,118	61,359	28.97	2
3	Registered Nurses	14,439	15,195	414,102	27.25	3
4	Licensed Practical Nurses	10,999	11,575	264,842	22.88	4
5	CNAs & Orderlies	54,430	57,280	728,729	12.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,393	3,571	55,433	15.52	8
9	Activity Director					9
10	Activity Assistants	4,886	5,142	63,695	12.39	10
11	Social Service Workers	2,529	2,662	33,312	12.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,248	21,308	190,820	8.96	15
16	Dishwashers					16
17	Maintenance Workers	2,253	2,371	33,923	14.31	17
18	Housekeepers	13,267	13,962	110,986	7.95	18
19	Laundry	3,695	3,889	28,165	7.24	19
20	Administrator	1,386	1,458	50,472	34.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,900	12,523	173,236	13.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,737	2,880	48,565	16.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,465	157,293	\$ 2,303,966 *	\$ 14.65	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		\$ 8,087	1-3	35
36	Medical Director	Contract	7,500	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		392	11-3	44
45	Social Service Consultant		3,470	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,449		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9,325	\$ 473,096	10-3	50
51	Licensed Practical Nurses	1,509	65,199	10-3	51
52	Certified Nurse Assistants/Aides	241	5,543	10-3	52
53	TOTAL (lines 50 - 52)	11,075	\$ 543,838		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Rosewood Care Center St Charles

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

**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 \$6,017
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,855 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 545
- (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 ST. CHARLES INC.  
IDPH ID #0041764  
ATTACHMENT TO SCHEDULE XIX, Section C  
6/30/2007

**PROFESSIONAL SERVICES:**

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
C. J. Schlosser & Co.	Accountant/Consultant	\$ 4,200
CT Corporation	Legal	473
Daniel Maher	Legal	8,658
Kutak Rock LLP	Legal	311
LarsonAllen	Accountant/Consultant	1,038
McCorkle Court Reporters, Inc.	Legal	488
MPRO		2,620
Pretzel & Stouffer, Chartered	Legal	23,637
Summers, Compton, Wells & Hamburg	Legal	100
Theresa Counts Burke	Legal	300
Total		41,825
Nonallowable legal fees		7,784
<b>Total Schedule V, Line 19, Col. 3</b>		<u><u>\$ 49,609</u></u>

ROSEWOOD CARE CENTER OF ST. CHARLES INC.  
IDPH ID #0041764  
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 JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC	MANAGEMENT CO.
MIDWEST ADMINISTRATIVE SERVICES, INC.	ADMINISTRATIVE CO.
ST. CHARLES REAL ESTATE, L.L.C.	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 ST. CHARLES  
IDPH ID #0041764  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2007

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 13,197</u>
	<u>\$ 13,197</u>

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