

		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: 0041038

Facility Name: Rosewood Care Center-Edwardsville

Address: 6277 Center Grove Road Edwardsville 62025
 Number City Zip Code

County: Madison

Telephone Number: (618) 659-0605 Fax # ()

HFS ID Number: _____

Date of Initial License for Current Owners: 6/16/95

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

(Signed) _____ (Date) _____

(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-Edwardsville

0041038 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>10,170</u>	<u>10,170</u>	8
9	SNF/PED					9
10	ICF	<u>3,757</u>	<u>14,465</u>		<u>18,222</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,757</u>	<u>14,465</u>	<u>10,170</u>	<u>28,392</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.82%

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 6/16/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/16/95 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 10,170

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-Edwardsville # 0041038 Report Period Beginning: 7/1/06 Ending: 6/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	183,908	16,821	6,478	207,207		207,207	2,969	210,176			1
2	Food Purchase		144,799		144,799		144,799	(3,780)	141,019			2
3	Housekeeping	113,493	28,210		141,703		141,703		141,703			3
4	Laundry	32,098	10,322		42,420		42,420		42,420			4
5	Heat and Other Utilities			167,677	167,677		167,677	140	167,817			5
6	Maintenance	38,095	13,842	149,505	201,442		201,442	(9,650)	191,792			6
7	Other (specify):* Sanitation			9,356	9,356		9,356		9,356			7
8	TOTAL General Services	367,594	213,994	333,016	914,604		914,604	(10,321)	904,283			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,706,317	180,093	271,718	2,158,128		2,158,128		2,158,128			10
10a	Therapy	62,082	6,770	647,938	716,790		716,790	18,704	735,494			10a
11	Activities	49,838	4,665	2,500	57,003		57,003		57,003			11
12	Social Services	49,082		2,300	51,382		51,382		51,382			12
13	CNA Training											13
14	Program Transportation			6	6		6		6			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,867,319	191,528	946,062	3,004,909		3,004,909	18,704	3,023,613			16
	C. General Administration											
17	Administrative	72,883		299,000	371,883		371,883	(294,146)	77,737			17
18	Directors Fees											18
19	Professional Services			94,941	94,941		94,941	(20,649)	74,292			19
20	Dues, Fees, Subscriptions & Promotions			66,154	66,154	995	67,149	(29,650)	37,499			20
21	Clerical & General Office Expenses	157,445	31,705	8,898	198,048		198,048	164,143	362,191			21
22	Employee Benefits & Payroll Taxes			332,605	332,605		332,605	29,314	361,919			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,978	1,978	(995)	983	9,824	10,807			24
25	Other Admin. Staff Transportation			17,951	17,951		17,951	8,471	26,422			25
26	Insurance-Prop.Liab.Malpractice			50,588	50,588		50,588	10,526	61,114			26
27	Other (specify):*											27
28	TOTAL General Administration	230,328	31,705	872,115	1,134,148		1,134,148	(122,167)	1,011,981			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,465,241	437,227	2,151,193	5,053,661		5,053,661	(113,784)	4,939,877			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-Edwardsville #0041038 Report Period Beginning: 7/1/06 Ending: 6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			3,399	3,399		3,399	137,618	141,017		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							256,206	256,206		32
33	Real Estate Taxes			95,899	95,899		95,899		95,899		33
34	Rent-Facility & Grounds			1,147,516	1,147,516		1,147,516	(1,127,931)	19,585		34
35	Rent-Equipment & Vehicles			33,358	33,358		33,358		33,358		35
36	Other (specify):* Mortgage Ins.							62,880	62,880		36
37	TOTAL Ownership			1,280,172	1,280,172		1,280,172	(671,227)	608,945		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		219,577	51,578	271,155		271,155		271,155		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	TOTAL Special Cost Centers		219,577	117,278	336,855		336,855		336,855		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,465,241	656,804	3,548,643	6,670,688		6,670,688	(785,011)	5,885,677		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-Edwardsville

0041038

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	(3,415)	2		4
5	Telephone, TV & Radio in Resident Rooms	(801)	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	(10,106)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(365)	2		13
14	Non-Care Related Interest	(429,963)	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	(32,750)	19		18
19	Entertainment	(105)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,445)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,854)	20		28
29	Other-Attach Schedule Marketing Salary	(64,306)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (575,110)		\$	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)	(209,901)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (209,901)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (785,011)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center-Edwardsville

ID# 0041038

Report Period Beginning: 7/1/06

Ending: 6/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (64,306)	21
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(64,306)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center-Edwardsville

0041038

Report Period Beginning:

7/1/06

Ending:

6/30/07

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,969	0	0	0	0	0	0	0	0	2,969	1
2	Food Purchase	(3,780)	0	0	0	0	0	0	0	0	0	0	(3,780)	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	140	0	0	0	0	0	0	0	0	140	5
6	Maintenance	0	0	11,810	(21,460)	0	0	0	0	0	0	0	(9,650)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,780)	0	14,919	(21,460)	0	(10,321)	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	18,704	0	0	0	0	0	0	0	0	0	18,704	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	18,704	0	0	0	0	0	0	0	0	0	18,704	16
	C. General Administration													
17	Administrative	0	(299,000)	4,854	0	0	0	0	0	0	0	0	(294,146)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,750)	0	12,101	0	0	0	0	0	0	0	0	(20,649)	19
20	Fees, Subscriptions & Promotions	(33,299)	0	3,649	0	0	0	0	0	0	0	0	(29,650)	20
21	Clerical & General Office Expenses	(65,107)	0	228,288	962	0	0	0	0	0	0	0	164,143	21
22	Employee Benefits & Payroll Taxes	0	0	26,857	2,457	0	0	0	0	0	0	0	29,314	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(105)	0	8,109	1,820	0	0	0	0	0	0	0	9,824	24
25	Other Admin. Staff Transportation	0	0	5,051	3,420	0	0	0	0	0	0	0	8,471	25
26	Insurance-Prop.Liab.Malpractice	0	4,094	6,103	329	0	0	0	0	0	0	0	10,526	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(131,261)	(294,906)	295,012	8,988	0	(122,167)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(135,041)	(276,202)	309,931	(12,472)	0	(113,784)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center-Edwardsville # 0041038 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	125,178	11,150	1,290	0	0	0	0	0	0	0	137,618	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(440,069)	696,275	0	0	0	0	0	0	0	0	0	256,206	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,147,516)	19,585	0	0	0	0	0	0	0	0	(1,127,931)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	62,880	0	0	0	0	0	0	0	0	0	62,880	36
37	TOTAL Ownership	(440,069)	(263,183)	30,735	1,290	0	(671,227)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(575,110)	(539,385)	340,666	(11,182)	0	(785,011)	45						

Facility Name & ID Number Rosewood Care Center-Edwardsville

0041038

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	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 102,600	HSM Management Services, Inc		\$	(102,600)	1
2	V	17 Administration Fee	196,400	Midwest Administrative Services, Inc.			(196,400)	2
3	V							3
4	V	10a Therapy	647,938	Rosewood Therapy Services, Inc.		666,642	18,704	4
5	V							5
6	V	34 Rent	1,147,516	Edwardsville Real Estate, Inc.			(1,147,516)	6
7	V	30 Depreciation		Edwardsville Real Estate, Inc.		125,178	125,178	7
8	V	32 Interest		Edwardsville Real Estate, Inc.		696,275	696,275	8
9	V	36 Mortgage Insurance		Edwardsville Real Estate, Inc.		62,880	62,880	9
10	V	26 Property Insurance		Edwardsville Real Estate, Inc.		4,094	4,094	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,094,454			\$ 1,555,069	\$ * (539,385)	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-Edwardsville# 0041038Report 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.		\$ 458	\$ 458	15	
16	V	19	See Schedule VIII			HSM Management Services Inc.		185	185	16	
17	V	20	See Schedule VIII			HSM Management Services Inc.		77	77	17	
18	V	21	See Schedule VIII			HSM Management Services Inc.		86,386	86,386	18	
19	V	22	See Schedule VIII			HSM Management Services Inc.		10,401	10,401	19	
20	V	24	See Schedule VIII			HSM Management Services Inc.		6,237	6,237	20	
21	V	25	See Schedule VIII			HSM Management Services Inc.		2,851	2,851	21	
22	V	26	See Schedule VIII			HSM Management Services Inc.		1,094	1,094	22	
23	V									23	
24	V									24	
25	V	1	See Schedule VIII			Midwest Administrative Services, Inc.		2,969	2,969	25	
26	V	5	See Schedule VIII			Midwest Administrative Services, Inc.		140	140	26	
27	V	6	See Schedule VIII			Midwest Administrative Services, Inc.		11,352	11,352	27	
28	V	17	See Schedule VIII			Midwest Administrative Services, Inc.		4,854	4,854	28	
29	V	19	See Schedule VIII			Midwest Administrative Services, Inc.		11,916	11,916	29	
30	V	20	See Schedule VIII			Midwest Administrative Services, Inc.		3,572	3,572	30	
31	V	21	See Schedule VIII			Midwest Administrative Services, Inc.		141,902	141,902	31	
32	V	22	See Schedule VIII			Midwest Administrative Services, Inc.		16,456	16,456	32	
33	V	24	See Schedule VIII			Midwest Administrative Services, Inc.		1,872	1,872	33	
34	V	25	See Schedule VIII			Midwest Administrative Services, Inc.		2,200	2,200	34	
35	V	26	See Schedule VIII			Midwest Administrative Services, Inc.		5,009	5,009	35	
36	V	30	See Schedule VIII			Midwest Administrative Services, Inc.		11,150	11,150	36	
37	V	34	See Schedule VIII			Midwest Administrative Services, Inc.		19,585	19,585	37	
38	V									38	
39	Total			\$				\$ 340,666	\$ * 340,666	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	\$ 48,992	Senior Living Services		\$ 27,532	\$ (21,460)	15
16	V	21	Clerical & Office Expense		Senior Living Services		962	962	16
17	V	22	Emp Ben & Payroll Taxes		Senior Living Services		2,457	2,457	17
18	V	24	Travel & Seminar		Senior Living Services		1,820	1,820	18
19	V	25	Other Admin Staff Transpotation		Senior Living Services		3,420	3,420	19
20	V	26	Insurance		Senior Living Services		329	329	20
21	V	30	Depreciation		Senior Living Services		1,290	1,290	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		\$ 48,992				\$ 37,810	\$ * (11,182)	39

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

Facility Name & ID Number Rosewood Care Center-Edwardsville # 0041038 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	75.00%	21,805	3	6.25%	Salary	\$ 1,455	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	50,942	3	6.25%	Salary	3,399	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	\$ 4,854		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-Edwardsville

0041038

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 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

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	\$	5,397,086	\$ 458	1
2	19	Professional Services	Total Cost	18	2,959		5,397,086	185	2
3	20	Dues & Subscriptions	Total Cost	18	1,227		5,397,086	77	3
4	21	Salaries - Other	Total Cost	18	1,347,750	1,347,750	5,397,086	84,300	4
5	21	Taxes, Licenses, & Office Supplies	Total Cost	18	27,744		5,397,086	1,735	5
6	21	Telephone	Total Cost	18	5,615		5,397,086	351	6
7	22	Payroll Taxes	Total Cost	18	114,437		5,397,086	7,158	7
8	22	Employee Benefits	Total Cost	18	51,850		5,397,086	3,243	8
9	24	Travel & Seminar	Total Cost	18	99,709		5,397,086	6,237	9
10	25	Other Admin Staff Transp	Total Cost	18	45,582		5,397,086	2,851	10
11	26	Insurances	Total Cost	18	17,489		5,397,086	1,094	11
12	17	Direct - Admin	Direct Cost	1	0		1	0	12
13	17	Direct - Admin	Direct Cost	17	197,668	197,668	0	0	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,919,346	\$ 1,545,418		\$ 107,689	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center-Edwardsville

0041038

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	5,397,086	\$ 2,969	1
2	5	Utilities	Total Cost	18	2,240		5,397,086	140	2
3	6	Maintenance	Total Cost	18	181,498	40,614	5,397,086	11,352	3
4	17	Salaries - Officers	Total Cost	18	77,601	77,601	5,397,086	4,854	4
5	19	Professional Services	Total Cost	18	190,504		5,397,086	11,916	5
6	20	Dues & Subscriptions	Total Cost	18	57,105		5,397,086	3,572	6
7	21	Salaries - Other	Total Cost	18	1,779,601	1,779,601	5,397,086	111,311	7
8	21	Clerical & Office Supplies	Total Cost	18	489,073		5,397,086	30,591	8
9	22	Payroll Taxes & Emp Ben.	Total Cost	18	263,096		5,397,086	16,456	9
10	24	Travel & Seminar	Total Cost	18	29,921		5,397,086	1,872	10
11	25	Other Admin Transp	Total Cost	18	35,177		5,397,086	2,200	11
12	26	Insurance	Total Cost	18	80,079		5,397,086	5,009	12
13	30	Depreciation	Total Cost	18	155,885		5,397,086	9,750	13
14	34	Building Rent	Total Cost	18	313,115		5,397,086	19,585	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	1,400		1	1,400	17
18	30	Direct - Depreciation	Direct Cost	17	20,110				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,828,977	\$ 2,050,388		\$ 232,977	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			
A. Directly Facility Related																				
Long-Term																				
1	Capmark		X	Refinance Mortgage	\$69,533.00	7/1/04	\$ 4,943,300	\$ 4,794,122	8/1/39	5.440%	\$ 262,399	1								
2	Amortization of Loan Fees										5,204	2								
3	Real Estate Company Interest Income										(1,291)	3								
4	Interest Income Offset										(10,106)	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$69,533.00		\$ 4,943,300	\$ 4,794,122			\$ 256,206	9								
B. Non-Facility Related*																				
10	Capmark		X	Refinance Mortgage		7/1/04	8,100,000	7,855,559	8/1/39	5.440%	429,963	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 8,100,000	\$ 7,855,559			\$ 429,963	14								
15	TOTALS (line 9+line14)						\$ 13,043,300	\$ 12,649,681			\$ 686,169	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 62,880 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-Edwardsville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0041038

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>14-1-15-22-00-000-002.004</u>	<u>S PT SE 15 & N PT NE 22</u>	\$ <u>99,069.47</u>	\$ <u>99,069.47</u>
2. <u>14-1-15-15-00-000-007.006</u>	<u>S PT SEC 15 LICENSE AGREEMEN</u>	\$ <u>2.66</u>	\$ <u>2.66</u>
3. _____	<u>FOR EDW SCHOOL DIST 7</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>99,072.13</u>	\$ <u>99,072.13</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-Edwardsville# 0041038 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 1C. 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).

NoneF. 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>496,222</u>	<u>1994</u>	<u>\$ 401,071</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	496,222		\$ 401,071	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center-Edwardsville**

0041038

Report Period Beginning:

7/1/06

Ending:

6/30/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1995	\$ 4,399,440	\$	25-40	\$ 114,234	\$ 114,234	\$ 1,380,333	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Signs			1995	14,335		10			14,335	9
10	Cable			1995	3,600		10			3,600	10
11	Emergency Generator			1995	27,359		10			27,359	11
12	Sinks			1995	12,598		10			12,598	12
13	Hydronic Boiler			1995	4,754		10			4,754	13
14	Water Heater			1995	6,382		10			6,382	14
15	Walk-In Cooler			1995	4,696		10			4,696	15
16	Exhaust Hood			1995	5,889		10			5,889	16
17	Fire/Door Alarm			1995	2,167		10			2,167	17
18	Flooring			1995	4,888		10			4,888	18
19	Paint/Wallcovering			1995	55,424		10			55,424	19
20	Fence			2000	3,445		25	138	138	919	20
21	Therapy Room Revisions			2002	22,981		40	575	575	3,208	21
22	Smoke Detectors			2002	2,127		10	213	213	975	22
23	Parking Lot Sealing & Striping			2004	4,360		2	363	363	4,360	23
24	Water Heater			2005	4,501		10	449	449	825	24
25	Smoke Check Closers			2006	2,547		15	85	85	85	25
26	2 Copper Exchange Boilers			2007	4,460		20	112	112	112	26
27	McQuay Parts			2007	3,379		10	112	112	112	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-Edwardsville

0041038

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	Leashold Improvements - Facility:		\$	\$		\$	\$	\$	37
38	Wallcovering	1996	251		7			251	38
39	Painting	1997	1,750		7			1,750	39
40	Communication System	1998	3,195		7			3,195	40
41	Carpet	1999	1,234		7			1,234	41
42	Computer Cabling	2000	2,392	342	7	342		2,250	42
43	Carpet	2005	5,425	775	7	775		1,938	43
44	Wallpaper	2005	4,940	706	7	706		1,470	44
45	Parking Lot Sealing & Striping	2005	4,610	659	7	659		1,098	45
46	Wallpaper	2005	5,620	801	7	801		1,471	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)		\$ 4,618,749	\$ 3,283		\$ 119,564	\$ 116,281	\$ 1,547,678	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-Edwardsville # 0041038 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	\$ 112,310	\$ 116	\$ 13,941	\$ 13,825	5-10 Yrs	\$ 55,705	71
72	Current Year Purchases	18,494		1,379	1,379	5-10 Yrs	1,379	72
73	Fully Depreciated Assets	546,616					546,616	73
74								74
75	TOTALS	\$ 677,420	\$ 116	\$ 15,320	\$ 15,204		\$ 603,700	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	\$ 20,985	\$	\$ 4,843	\$ 4,843	4 Yrs	\$ 5,530	76
77	Senior Living Services	Various	Various	6,198		1,290	1,290	4 Yrs	1,486	77
78										78
79										79
80	TOTALS			\$ 27,183	\$	\$ 6,133	\$ 6,133		\$ 7,016	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)	\$ 5,724,423	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,399	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,017	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 137,618	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,158,394	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rosewood Care Center-Edwardsville # 0041038 Report Period Beginning: 7/1/06 Ending: 6/30/07

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$	14,724	\$ 254,055	\$	14,724	\$ 254,055	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		3,539	50,572		3,539	50,572	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		27,713	362,015	6,770	27,713	368,785	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				204,241		204,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Enterals, X-Ray Other (specify): & Lab Fees	39-8				51,578	15,336		66,914	13
14	TOTAL			\$	45,976	\$ 718,220	\$ 226,347	45,976	\$ 944,567	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-Edwardsville# 0041038Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (44,108)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>70,000</u>)	715,702		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,919		6
7	Other Prepaid Expenses	12,925		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 695,438	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	30,222		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(15,285)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,937	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 710,375	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 225,241	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,338		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,933		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,835		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	69,600		35
	Other Current Liabilities(specify):			
36	<u>Accrued Fees - Related Parties</u>	66,868		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 582,815	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 582,815	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 127,560	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 710,375	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 117,515	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 117,515	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	10,045	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,045	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 127,560	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center-Edwardsville# 0041038Report Period Beginning: 7/1/06Ending: 6/30/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,881,287	1
2	Discounts and Allowances for all Levels	(2,448,335)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,432,952	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,230,498	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,230,498	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,400	13
14	Non-Patient Meals	3,415	14
15	Telephone, Television and Radio	801	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,616	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,106	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	561	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 561	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,680,733	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	914,604	31
32	Health Care	3,004,909	32
33	General Administration	1,134,148	33
B. Capital Expense			
34	Ownership	1,280,172	34
C. Ancillary Expense			
35	Special Cost Centers	271,155	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,670,688	40
41	Income before Income Taxes (line 30 minus line 40)**	10,045	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,045	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-Edwardsville

0041038

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	2,022	2,130	\$ 63,866	\$ 29.98	1
2	Assistant Director of Nursing	2,055	2,165	58,634	27.08	2
3	Registered Nurses	12,488	13,153	329,742	25.07	3
4	Licensed Practical Nurses	25,689	27,059	566,478	20.93	4
5	CNAs & Orderlies	53,688	56,549	616,050	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,485	3,670	62,082	16.92	8
9	Activity Director					9
10	Activity Assistants	5,164	5,439	49,838	9.16	10
11	Social Service Workers	3,655	3,850	49,082	12.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,332	21,416	183,908	8.59	15
16	Dishwashers					16
17	Maintenance Workers	2,252	2,372	38,095	16.06	17
18	Housekeepers	13,272	13,980	113,493	8.12	18
19	Laundry	4,024	4,239	32,098	7.57	19
20	Administrator	2,003	2,110	72,883	34.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,495	12,108	157,445	13.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,733	4,985	71,547	14.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,357	175,225	\$ 2,465,241 *	\$ 14.07	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	285	\$ 6,478	1-3	35
36	Medical Director	Contract	21,600	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	150	2,500	11-3	44
45	Social Service Consultant	140	2,300	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	\$ 32,878		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	845	\$ 36,756	10-3	50
51	Licensed Practical Nurses	2,381	79,106	10-3	51
52	Certified Nurse Assistants/Aides	8,734	155,856	10-3	52
53	TOTAL (lines 50 - 52)	11,960	\$ 271,718		53

SEE ACCOUNTANTS' COMPILATION REPORT

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. \$ 46,382 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. \$ 3,415
- (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 EDWARDSVILLE INC.
 IDPH ID #0041038
 ATTACHMENT TO SCHEDULE XIX, Section C
 6/30/2007

PROFESSIONAL SERVICES:

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
Becker Paulson Hoerner & Thompson	Legal	\$5,805
Charlene Hunter		1,353
C. J. Schlosser & Co.	Accountant/Consultant	4,200
CT Corporation	Annual Reports	473
Daniel Maher	Legal	16,055
Kevin Konzen, M. D.	Expert Witness	750
Kutak Rock LLP	Legal	275
LarsonAllen	Accountant/Consultant	187
Insurance Reimbursement		(8,078)
Insurance Reimbursement		(3,099)
Insurance Reimbursement		(5,388)
Nelson Bros.Schroder Ins.	Surety Bond	50
Old Republic Surety Group	Surety Bond	50
Pathway Health Services, Inc.	Expert Witness	1,000
Paul Scherer, M. D.	Deposition Fee	1,000
Quintairos, Prieto, Wood & Boyer, P. A.	Legal	4,289
Sandberg, Phoenix & von Gontard	Legal	40,006
Summers, Compton, Wells & Hamburg	Legal	1,792
Theresa Counts Burke	Legal	1,471
Total		\$62,191
Penalties		32,750
Total Schedule V, Line 19, Col. 3		94,941

ROSEWOOD CARE CENTER OF EDWARDSVILLE, INC.
IDPH ID #0041038
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 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. 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.
EDWARDSVILLE REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
SENIOR LIVING SERVICES, INC.	BLDG SERVICES CO.
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY

ROSEWOOD CARE CENTER OF EDWARDSVILLE INC.
IDPH ID #0041038
RECLASSIFICATIONS
6/30/2007

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(995)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	995	20

ROSEWOOD CARE CENTER OF EDWARDSVILLE, INC.
IDPH ID #0041038
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2007

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 17,951</u>
	<u><u>\$ 17,951</u></u>

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