

		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: 0035204

Facility Name: Rosewood Care Center of East Peoria

Address: 900 Centennial Drive East Peoria 61611
 Number City Zip Code

County: Tazewell

Telephone Number: (309) 699-5400 Fax # ()

HFS ID Number: 431446788001

Date of Initial License for Current Owners: 4/18/89

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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>Cindy A Tefteller</u>	
	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u>	
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 466-7710</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204 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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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			6,069	6,069	8
9	SNF/PED					9
10	ICF	13,454	11,850		25,304	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,454	11,850	6,069	31,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.63%

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 4/19/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/19/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 36 and days of care provided 6,069

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 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	173,153	19,386	7,257	199,796		199,796	2,330	202,126		1
2	Food Purchase		154,580		154,580		154,580	(5,351)	149,229		2
3	Housekeeping	116,467	30,163		146,630		146,630		146,630		3
4	Laundry	42,801	9,596		52,397		52,397		52,397		4
5	Heat and Other Utilities			122,781	122,781		122,781	110	122,891		5
6	Maintenance	22,883	21,081	150,774	194,738		194,738	(19,719)	175,019		6
7	Other (specify):* Sanitation			11,064	11,064		11,064		11,064		7
8	TOTAL General Services	355,304	234,806	291,876	881,986		881,986	(22,630)	859,356		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,569,012	167,128	290,762	2,026,902		2,026,902		2,026,902		10
10a	Therapy	58,248	5,226	402,350	465,824		465,824	25,395	491,219		10a
11	Activities	44,763	3,724	1,008	49,495		49,495		49,495		11
12	Social Services	36,264	3	1,572	37,839		37,839		37,839		12
13	CNA Training										13
14	Program Transportation			554	554		554		554		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,708,287	176,081	710,646	2,595,014		2,595,014	25,395	2,620,409		16
	C. General Administration										
17	Administrative	44,696		389,700	434,396		434,396	(385,891)	48,505		17
18	Directors Fees										18
19	Professional Services			64,915	64,915		64,915	(286)	64,629		19
20	Dues, Fees, Subscriptions & Promotions			37,370	37,370	1,990	39,360	(10,767)	28,593		20
21	Clerical & General Office Expenses	139,152	24,314	10,454	173,920		173,920	122,084	296,004		21
22	Employee Benefits & Payroll Taxes			287,635	287,635		287,635	24,190	311,825		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,189	7,189	(1,990)	5,199	8,507	13,706		24
25	Other Admin. Staff Transportation			6,903	6,903		6,903	8,297	15,200		25
26	Insurance-Prop.Liab.Malpractice			51,140	51,140		51,140	9,300	60,440		26
27	Other (specify):*										27
28	TOTAL General Administration	183,848	24,314	855,306	1,063,468		1,063,468	(224,566)	838,902		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,247,439	435,201	1,857,828	4,540,468		4,540,468	(221,801)	4,318,667		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of East Peoria #0035204 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			12,084	12,084		12,084	162,038	174,122			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							495,990	495,990			32
33	Real Estate Taxes			66,368	66,368		66,368		66,368			33
34	Rent-Facility & Grounds			1,016,823	1,016,823		1,016,823	(1,001,454)	15,369			34
35	Rent-Equipment & Vehicles			54,417	54,417		54,417		54,417			35
36	Other (specify):* Mortgage Ins.							50,742	50,742			36
37	TOTAL Ownership			1,149,692	1,149,692		1,149,692	(292,684)	857,008			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,132	31,029	185,161		185,161		185,161			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		154,132	96,729	250,861		250,861		250,861			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,247,439	589,333	3,104,249	5,941,021		5,941,021	(514,485)	5,426,536			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

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	(5,062)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,209)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(289)	2		13
14	Non-Care Related Interest				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	(162)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,782)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,347)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,283)	20		28
29	Other-Attach Schedule Marketing Salary	(58,284)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,418)		\$	30

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(412,067)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (412,067)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (514,485)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of East Peoria

ID# 0035204

Report Period Beginning: 7/1/06

Ending: 6/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (58,284)	21
2			
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49	Total	(58,284)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

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	2,330	0	0	0	0	0	0	0	0	2,330	1
2	Food Purchase	(5,351)	0	0	0	0	0	0	0	0	0	0	(5,351)	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	110	0	0	0	0	0	0	0	0	110	5
6	Maintenance	0	0	9,268	(28,987)	0	0	0	0	0	0	0	(19,719)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,351)	0	11,708	(28,987)	0	(22,630)	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	25,395	0	0	0	0	0	0	0	0	0	25,395	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	25,395	0	0	0	0	0	0	0	0	0	25,395	16
	C. General Administration													
17	Administrative	0	(389,700)	3,809	0	0	0	0	0	0	0	0	(385,891)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,782)	0	9,496	0	0	0	0	0	0	0	0	(286)	19
20	Fees, Subscriptions & Promotions	(13,630)	0	2,863	0	0	0	0	0	0	0	0	(10,767)	20
21	Clerical & General Office Expenses	(58,284)	0	179,149	1,219	0	0	0	0	0	0	0	122,084	21
22	Employee Benefits & Payroll Taxes	0	0	21,076	3,114	0	0	0	0	0	0	0	24,190	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(162)	0	6,363	2,306	0	0	0	0	0	0	0	8,507	24
25	Other Admin. Staff Transportation	0	0	3,964	4,333	0	0	0	0	0	0	0	8,297	25
26	Insurance-Prop.Liab.Malpractice	0	4,094	4,789	417	0	0	0	0	0	0	0	9,300	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(81,858)	(385,606)	231,509	11,389	0	(224,566)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,209)	(360,211)	243,217	(17,598)	0	(221,801)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 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	151,631	8,772	1,635	0	0	0	0	0	0	0	162,038	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,209)	511,199	0	0	0	0	0	0	0	0	0	495,990	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,016,823)	15,369	0	0	0	0	0	0	0	0	(1,001,454)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	50,742	0	0	0	0	0	0	0	0	0	50,742	36
37	TOTAL Ownership	(15,209)	(303,251)	24,141	1,635	0	(292,684)	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)	(102,418)	(663,462)	267,358	(15,963)	0	(514,485)	45						

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

Report Period Beginning:

7/1/06

Ending:

6/30/07

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75%	See Attached List		See Attached List		
Darrell Hoefling	25%	See Attached List		See Attached List		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 102,600	HSM Management Services, Inc		\$	(102,600)	1
2	V	17 Administration Fee	287,100	Midwest Administrative Services, Inc.			(287,100)	2
3	V							3
4	V	10a Therapy	402,350	Rosewood Therapy Services, Inc.		427,745	25,395	4
5	V							5
6	V	34 Rent	1,016,823	East Peoria Real Estate, Inc.			(1,016,823)	6
7	V	30 Depreciation		East Peoria Real Estate, Inc.		151,631	151,631	7
8	V	32 Interest		East Peoria Real Estate, Inc.		511,199	511,199	8
9	V	36 Mortgage Insurance		East Peoria Real Estate, Inc.		50,742	50,742	9
10	V	26 Property Insurance		East Peoria Real Estate, Inc.		4,094	4,094	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,808,873			\$ 1,145,411	\$ * (663,462)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204Report 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.		\$ 359	\$ 359	15	
16	V	19	See Schedule VIII			HSM Management Services Inc.		145	145	16	
17	V	20	See Schedule VIII			HSM Management Services Inc.		60	60	17	
18	V	21	See Schedule VIII			HSM Management Services Inc.		67,792	67,792	18	
19	V	22	See Schedule VIII			HSM Management Services Inc.		8,162	8,162	19	
20	V	24	See Schedule VIII			HSM Management Services Inc.		4,894	4,894	20	
21	V	25	See Schedule VIII			HSM Management Services Inc.		2,237	2,237	21	
22	V	26	See Schedule VIII			HSM Management Services Inc.		858	858	22	
23	V									23	
24	V									24	
25	V	1	See Schedule VIII			Midwest Administrative Services, Inc.		2,330	2,330	25	
26	V	5	See Schedule VIII			Midwest Administrative Services, Inc.		110	110	26	
27	V	6	See Schedule VIII			Midwest Administrative Services, Inc.		8,909	8,909	27	
28	V	17	See Schedule VIII			Midwest Administrative Services, Inc.		3,809	3,809	28	
29	V	19	See Schedule VIII			Midwest Administrative Services, Inc.		9,351	9,351	29	
30	V	20	See Schedule VIII			Midwest Administrative Services, Inc.		2,803	2,803	30	
31	V	21	See Schedule VIII			Midwest Administrative Services, Inc.		111,357	111,357	31	
32	V	22	See Schedule VIII			Midwest Administrative Services, Inc.		12,914	12,914	32	
33	V	24	See Schedule VIII			Midwest Administrative Services, Inc.		1,469	1,469	33	
34	V	25	See Schedule VIII			Midwest Administrative Services, Inc.		1,727	1,727	34	
35	V	26	See Schedule VIII			Midwest Administrative Services, Inc.		3,931	3,931	35	
36	V	30	See Schedule VIII			Midwest Administrative Services, Inc.		8,772	8,772	36	
37	V	34	See Schedule VIII			Midwest Administrative Services, Inc.		15,369	15,369	37	
38	V									38	
39	Total			\$				\$ 267,358	\$ * 267,358	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	\$ 62,075	Senior Living Services		\$ 33,088	\$ (28,987)	15
16	V	21 Clerical & Office Expenses		Senior Living Services		1,219	1,219	16
17	V	22 Employee Benefits & Payroll Tax		Senior Living Services		3,114	3,114	17
18	V	24 Travel & Seminar		Senior Living Services		2,306	2,306	18
19	V	25 Other Admin Staff Transportation		Senior Living Services		4,333	4,333	19
20	V	26 Insurance		Senior Living Services		417	417	20
21	V	30 Depreciation		Senior Living Services		1,635	1,635	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		\$ 62,075			\$ 46,112	\$ * (15,963)	39

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

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 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	0.75	22,119	2	4.97%	Salary	\$ 1,142	17-8	1
2	Darrell Hoefling	Vice President	Management	0.25	51,673	2	4.97%	Salary	2,667	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	\$ 3,809		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

Report Period Beginning:

7/1/06

Ending: 6/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Total Cost	18	\$ 7,316	\$	4,235,339	\$ 359	1
2	19	Professional Services	Total Cost	18	2,959		4,235,339	145	2
3	20	Dues & Subscriptions	Total Cost	18	1,227		4,235,339	60	3
4	21	Salaries - Other	Total Cost	18	1,347,750	1,347,750	4,235,339	66,154	4
5	21	Taxes, Licenses, & Office Supplies	Total Cost	18	27,744		4,235,339	1,362	5
6	21	Telephone	Total Cost	18	5,615		4,235,339	276	6
7	22	Payroll taxes	Total Cost	18	114,437		4,235,339	5,617	7
8	22	Employee Benefits	Total Cost	18	51,850		4,235,339	2,545	8
9	24	Travel & Seminar	Total Cost	18	99,709		4,235,339	4,894	9
10	25	Other Admin Staff Transp	Total Cost	18	45,582		4,235,339	2,237	10
11	26	Insurance	Total Cost	18	17,489		4,235,339	858	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		\$ 84,507	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

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 86,286,551	18	\$ 47,460	\$ 47,460	4,235,339	\$ 2,330	1
2	5	Utilities	Total Cost 86,286,551	18	2,240		4,235,339	110	2
3	6	Maintenance	Total Cost 86,286,551	18	181,498	40,614	4,235,339	8,909	3
4	17	Salaries - Officers	Total Cost 86,286,551	18	77,601	77,601	4,235,339	3,809	4
5	19	Professional Services	Total Cost 86,286,551	18	190,504		4,235,339	9,351	5
6	20	Dues & Subscriptions	Total Cost 86,286,551	18	57,105		4,235,339	2,803	6
7	21	Salaries - Other	Total Cost 86,286,551	18	1,779,601	1,779,601	4,235,339	87,351	7
8	21	Clerical & Office Supplies	Total Cost 86,286,551	18	489,073		4,235,339	24,006	8
9	22	Payroll Taxes & Emp Ben.	Total Cost 86,286,551	18	263,096		4,235,339	12,914	9
10	24	Travel & Seminar	Total Cost 86,286,551	18	29,921		4,235,339	1,469	10
11	25	Other Admin Transp	Total Cost 86,286,551	18	35,177		4,235,339	1,727	11
12	26	Insurance	Total Cost 86,286,551	18	80,079		4,235,339	3,931	12
13	30	Depreciation	Total Cost 86,286,551	18	155,885		4,235,339	7,652	13
14	34	Building Rent	Total Cost 86,286,551	18	313,115		4,235,339	15,369	14
15	17	Direct - Admin	Direct Cost 1	1			1		15
16	17	Direct - Admin	Direct Cost 17	17	105,112	105,112			16
17	30	Direct - Depreciation	Direct Cost 1	1	1,120		1	1,120	17
18	30	Direct - Depreciation	Direct Cost 17	17	20,390				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,828,977	\$ 2,050,388		\$ 182,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capmark		X	Mortgage	\$53,554.00	10/1/03	\$ 10,665,100	\$ 10,209,093	11/1/38	4.96%	\$ 509,963	1
2	Less: Interest Income										(15,209)	2
3	Amortization of Loan Costs										3,097	3
4	Real Estate Company Interest Income										(1,861)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$53,554.00		\$ 10,665,100	\$ 10,209,093			\$ 495,990	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 10,665,100	\$ 10,209,093			\$ 495,990	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 50,742 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 of East Peoria# 0035204 Report Period Beginning: 7/1/06Ending: 6/30/07

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2006 report.			\$	96,321	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	96,537	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	216	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	66,152	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	66,368	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2002	<u>63,027</u>	<u>8</u>			
	2003	<u>64,572</u>	<u>9</u>			
	2004	<u>65,637</u>	<u>10</u>			
	2005	<u>63,789</u>	<u>11</u>			
	2006	<u>65,497</u>	<u>12</u>			
<u>2005 Payment = \$63,789</u>						
<u>2006 Payment = \$32,748</u>						
<u>Accrual = Balance of 2006 tax bill (\$32,749) + 1/2 of estimated 2007 tax bill (\$33,403)</u>						
				FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006	\$			13
	14	PLUS APPEAL COST FROM LINE 5	\$			14
	15	LESS REFUND FROM LINE 6	\$			15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

- 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 of East Peoria COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0035204

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>01-01-24-100-024</u>	<u>900 Centennial Dr</u>	<u>\$ 65,496.94</u>	<u>\$ 65,496.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 65,496.94	\$ 65,496.94

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204 Report Period Beginning:

7/1/06 Ending:

6/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>301,000</u>	<u>1988</u>	<u>\$ 77,830</u>	1
2					2
3	TOTALS	301,000		\$ 77,830	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

0035204

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			1989	\$ 2,953,579	\$	10-25	\$ 117,446	\$ 117,446	\$ 2,371,490	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements - Original Construction			1989	209,624		15-25	7,165	7,165	177,435	9
10	Fence			1990	2,377		25	95	95	1,521	10
11	Concrete Work			1991	5,190		25	207	207	3,326	11
12	Painting			1992	7,694		5			7,694	12
13	Irrigation System			1993	10,175		25	407	407	5,732	13
14	Generator			1989	14,937		10			14,937	14
15	Signs			1989	3,157		10			3,157	15
16	Walk-in Cooler			1989	5,770		20	289	289	5,272	16
17	Sinks			1989	3,744		10			3,744	17
18	Exhaust Hood			1989	4,621		10			4,621	18
19	Fire System			1989	1,271		20	64	64	1,166	19
20	Carpeting			1989	10,368		10			10,368	20
21	Cubicle Track			1989	6,294		10			6,294	21
22	Door Installation			1991	2,750		10			2,750	22
23	Sprinkler Addition			1992	786		10			786	23
24	Ceramic Sink			1994	2,011		10			2,011	24
25	Parking Lot Extension			2003	37,489		25	1,500	1,500	5,373	25
26	Shingle Roof Replacement			2004	97,105		10	9,710	9,710	25,895	26
27	Patient Room Sinks			2006	12,035		20	602	602	752	27
28	Heat Pumps			2006	28,515		10	2,852	2,852	3,406	28
29	Door Closers			2005	2,870		15	191	191	287	29
30	Cooling Tower			2007	47,061		10	784	784	784	30
31	2 Copper Exchange Boilers			2006	4,400		20	128	128	128	31
32	Seal & Stripe Parking Lot			2006	3,275		2	1,228	1,228	1,228	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 of East Peoria

0035204

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	Leasehold Improvements - Facility:		\$	\$	7	\$	\$	\$	37
38	Carpeting	1994	3,238		7			3,238	38
39	Painting, Baseboard Stripping, Drapery, Tile, Carpet	1995	37,083		7			37,083	39
40	Painting/Tiling	1996	3,960		7			3,960	40
41	Wallpaper	1998	3,525		7			3,525	41
42	Floor Covering/Wallpaper/Plants	1998	18,546		7			18,546	42
43	Min Blinds / Wallcovering	1999	5,486		7			5,486	43
44	Carpeting	1999	4,375	104	7	104		4,375	44
45	Computer Cabling	2000	2,392	342	7	342		2,250	45
46	Computer Receptacles	2001	214	31	7	31		199	46
47	Doors	2001	5,966	852	7	852		5,327	47
48	Parking Lot	2001	11,475	1,638	7	1,638		10,108	48
49	Drapes, Wallcoverings, Head Wallcoverings	2001	27,188	3,883	7	3,883		22,886	49
50	Drapery	2003	1,237	177	7	177		780	50
51	Painting	2003	3,112	445	7	445		1,926	51
52	Flooring	2005	3,491	499	7	499		1,122	52
53	Painting	2007	12,610	751	7	751		751	53
54	Painting	2006	17,459	1,744	7	1,744		1,744	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,638,455	\$ 10,466		\$ 153,134	\$ 142,668	\$ 2,783,463	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center of East Peoria # 0035204 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	\$ 138,165	\$ 1,618	\$ 14,844	\$ 13,226	5-10 Yrs	\$ 91,454	71
72	Current Year Purchases	5,294		709	709	5-10 Yrs	709	72
73	Fully Depreciated Assets	374,220					374,220	73
74								74
75	TOTALS	\$ 517,679	\$ 1,618	\$ 15,553	\$ 13,935		\$ 466,383	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	\$ 16,468	\$	\$ 3,800	\$ 3,800	4 Yrs	\$ 4,339	76
77	Senior Living Services	Various	Various	7,854		1,635	1,635	4 Yrs	1,883	77
78										78
79										79
80	TOTALS			\$ 24,322	\$	\$ 5,435	\$ 5,435		\$ 6,222	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)	\$ 4,258,286	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,084	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,122	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 162,038	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,256,068	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 of East Peoria # 0035204 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	\$	14,552	\$ 218,934	\$	14,552	\$ 218,934	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,239	750		1,239	750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		12,559	208,062	5,226	12,559	213,288	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				132,236		132,236	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals Other (specify): <u>I.V. Therapy, X-Ray</u>	39-8				31,029	21,896		52,925	13
14	TOTAL			\$	28,350	\$ 458,774	\$ 159,358	28,350	\$ 618,132	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204Report 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	\$ (77,977)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>70,000</u>)	898,360		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,149		6
7	Other Prepaid Expenses	5,726		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 828,258	\$	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	172,681		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(134,198)		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)	\$ 38,483	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 866,741	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 232,249	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,447		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,892		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,152		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	19,600		35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses - Related Parties</u>	64,870		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 544,210	\$	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)	\$ 544,210	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 322,531	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 866,741	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 299,897	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 299,897	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	72,634	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	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 22,634	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)	\$ 322,531	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria# 0035204Report 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	\$ 6,081,519	1
2	Discounts and Allowances for all Levels	(1,452,204)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,629,315	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,359,159	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,359,159	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	4,688	13
14	Non-Patient Meals	5,062	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,750	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,209	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,209	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	222	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,013,655	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	881,986	31
32	Health Care	2,595,014	32
33	General Administration	1,063,468	33
B. Capital Expense			
34	Ownership	1,149,692	34
C. Ancillary Expense			
35	Special Cost Centers	185,161	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)*	\$ 5,941,021	40
41	Income before Income Taxes (line 30 minus line 40)**	72,634	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 72,634	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 of East Peoria

0035204

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	2,075	2,182	\$ 72,869	\$ 33.40	1
2	Assistant Director of Nursing	1,132	1,191	30,883	25.93	2
3	Registered Nurses	10,453	10,994	262,361	23.86	3
4	Licensed Practical Nurses	18,100	19,038	389,367	20.45	4
5	CNAs & Orderlies	60,982	64,140	738,236	11.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,265	3,434	58,248	16.96	8
9	Activity Director					9
10	Activity Assistants	4,884	5,137	44,763	8.71	10
11	Social Service Workers	3,407	3,583	36,264	10.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,580	20,594	173,153	8.41	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,106	22,883	10.87	17
18	Housekeepers	13,926	14,648	116,467	7.95	18
19	Laundry	5,474	5,758	42,801	7.43	19
20	Administrator	1,471	1,547	44,696	28.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,553	12,151	139,152	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,189	5,458	75,296	13.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,493	171,961	\$ 2,247,439 *	\$ 13.07	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	320	\$ 7,257	1-3	35
36	Medical Director	Contract	14,400	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	60	1,008	11-3	44
45	Social Service Consultant	90	1,572	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 24,237		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,469	\$ 88,894	10-3	50
51	Licensed Practical Nurses	5,834	199,372	10-3	51
52	Certified Nurse Assistants/Aides	125	2,496	10-3	52
53	TOTAL (lines 50 - 52)	8,428	\$ 290,762		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of East Peoria

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

Facility Name & ID Number Rosewood Care Center of East Peoria

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. \$ 39,137 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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,062
- (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 EAST PEORIA INC.
IDPH ID #0035204
ATTACHMENT TO SCHEDULE XIX, Section C
6/30/2007

PROFESSIONAL SERVICES:

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
Bruce L Gewer	Expert Witness	\$1,500
C. J. Schlosser & Co	Accountant/Consultant	4,200
CT Corporation	Legal	473
Daniel Maher	Legal	6,524
Hinshaw & Culbertson, LLP	Legal	7,628
Knight Reporting	Court Reporter	250
Kutak Rock LLP	Legal	312
Lane & Waterman LLP	Legal	552
Lowenbaum Partnership	Legal	32,080
Old Republic Surety Group		50
Pathway Health Services, Inc.		500
Summers, Compton, Wells & Hamburg	Legal	139
Theresa Counts Burke	Legal	925
		<u>\$55,132</u>
Nonallowable legal Fees	Collection	<u>9,782</u>
Total		<u><u>64,914</u></u>

ROSEWOOD CARE CENTER OF EAST PEORIA, INC.
IDPH ID #0035204
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2007

RELATED NURSING HOME:	CITY:
ROSEWOOD CARE CENTER OF ALTON	ALTON, 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. 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.
EAST PEORIA 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 EAST PEORIA
IDPH ID #0035204
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2007

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 6,903</u>
	<u><u>\$ 6,903</u></u>

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

ROSEWOOD CARE CENTER OF EAST PEORIA
IDPH ID #0035204
ATTACHMENT TO SCHEDULE V
6/30/2007

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