



Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	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			1,731	1,731	8
9	SNF/PED					9
10	ICF	28,674	1,910	15	30,599	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,674	1,910	1,746	32,330	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.30%

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

None (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)

N/A

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 3/1/96

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

YES  Date 3/1/96 NO

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

YES  NO  If YES, enter number of beds certified 53 and days of care provided 1,731

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTE # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	170,957	22,632	8,181	201,770		201,770		201,770		1
2	Food Purchase		146,062		146,062		146,062	(102)	145,960		2
3	Housekeeping	111,651	21,469		133,120		133,120		133,120		3
4	Laundry	64,356	8,146		72,502		72,502		72,502		4
5	Heat and Other Utilities			110,910	110,910		110,910	2,812	113,722		5
6	Maintenance	55,801	421	58,282	114,504		114,504	5,191	119,695		6
7	Other (specify):*							5	5		7
8	<b>TOTAL General Services</b>	<b>402,765</b>	<b>198,730</b>	<b>177,373</b>	<b>778,868</b>		<b>778,868</b>	<b>7,906</b>	<b>786,774</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,100	10,100		10,100		10,100		9
10	Nursing and Medical Records	1,273,131	67,880	6,980	1,347,991		1,347,991	4,303	1,352,294		10
10a	Therapy	161,094		28,454	189,548		189,548	708	190,256		10a
11	Activities	42,071	4,878	10,671	57,620		57,620		57,620		11
12	Social Services	112,426		4,118	116,544		116,544		116,544		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,588,722</b>	<b>72,758</b>	<b>60,323</b>	<b>1,721,803</b>		<b>1,721,803</b>	<b>5,011</b>	<b>1,726,814</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	71,630		90,000	161,630		161,630	(60,609)	101,021		17
18	Directors Fees										18
19	Professional Services			162,393	162,393		162,393	(22,695)	139,698		19
20	Dues, Fees, Subscriptions & Promotions			46,085	46,085		46,085	(19,160)	26,925		20
21	Clerical & General Office Expenses	129,498	18,884	61,230	209,612		209,612	22,333	231,945		21
22	Employee Benefits & Payroll Taxes			324,320	324,320		324,320		324,320		22
23	Inservice Training & Education							253	253		23
24	Travel and Seminar			7,879	7,879		7,879	272	8,151		24
25	Other Admin. Staff Transportation			25,517	25,517		25,517	4,626	30,143		25
26	Insurance-Prop.Liab.Malpractice			97,484	97,484		97,484	717	98,201		26
27	Other (specify):*							16,467	16,467		27
28	<b>TOTAL General Administration</b>	<b>201,128</b>	<b>18,884</b>	<b>814,908</b>	<b>1,034,920</b>		<b>1,034,920</b>	<b>(57,796)</b>	<b>977,124</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,192,615</b>	<b>290,372</b>	<b>1,052,604</b>	<b>3,535,591</b>		<b>3,535,591</b>	<b>(44,879)</b>	<b>3,490,712</b>		<b>29</b>

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

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 ROSE GARDEN CONVALESCENT CENTER #0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			36,381	36,381	36,381	68,162	104,543			30
31	Amortization of Pre-Op. & Org.						64	64			31
32	Interest			22,643	22,643	22,643	189,291	211,934			32
33	Real Estate Taxes			61,400	61,400	61,400	(13,817)	47,583			33
34	Rent-Facility & Grounds			290,794	290,794	290,794	(290,794)				34
35	Rent-Equipment & Vehicles			23,719	23,719	23,719	1,366	25,085			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			434,937	434,937	434,937	(45,728)	389,209			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			70,857	70,857	70,857		70,857			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			60,390	60,390	60,390		60,390			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			131,247	131,247	131,247		131,247			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,192,615	290,372	1,618,788	4,101,775	4,101,775	(90,607)	4,011,168			45

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780

Report Period Beginning: 1/01/08

Ending: 12/31/08

**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				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	(28,023)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(102)	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				17
18	Fines and Penalties	(11,462)	21		18
19	Entertainment				19
20	Contributions	(580)	21		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	(16,946)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,683)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (79,796)		\$	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)	(10,811)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (10,811)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (90,607)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
ROSE GARDEN CONVALESCENT CENTER

ID# 0041780

Report Period Beginning: 1/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	\$ (3,103)	20	1
2	OTHER EXPENSE ADJUSTMENTS	7,564	21	2
3	BANK CHARGES	(11,000)	21	3
4	TAXES - GENERAL	(169)	21	4
5	REAL ESTATE TAX ADJ	(15,975)	33	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	<b>Total</b>	(22,683)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780

Report Period Beginning:

1/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(102)	0	0	0	0	0	0	0	0	0	0	(102)	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	2,801	0	11	0	0	0	0	0	0	2,812	5
6	Maintenance	0	0	3,270	0	1,921	0	0	0	0	0	0	5,191	6
7	Other (specify):*	0	0	0	0	5	0	0	0	0	0	0	5	7
8	<b>TOTAL General Services</b>	<b>(102)</b>	<b>0</b>	<b>6,071</b>	<b>0</b>	<b>1,937</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,906</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	4,303	0	0	0	0	0	0	4,303	10
10a	Therapy	0	0	0	0	708	0	0	0	0	0	0	708	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,011</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,011</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(64,507)	(10,000)	13,898	0	0	0	0	0	0	(60,609)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,652	(28,412)	2,065	0	0	0	0	0	0	(22,695)	19
20	Fees, Subscriptions & Promotions	(20,049)	0	407	0	482	0	0	0	0	0	0	(19,160)	20
21	Clerical & General Office Expenses	(15,647)	0	41,697	(16,000)	12,283	0	0	0	0	0	0	22,333	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	253	0	0	0	0	0	0	253	23
24	Travel and Seminar	0	0	263	0	9	0	0	0	0	0	0	272	24
25	Other Admin. Staff Transportation	0	0	3,119	0	1,507	0	0	0	0	0	0	4,626	25
26	Insurance-Prop.Liab.Malpractice	0	0	426	0	291	0	0	0	0	0	0	717	26
27	Other (specify):*	0	0	9,902	0	6,565	0	0	0	0	0	0	16,467	27
28	<b>TOTAL General Administration</b>	<b>(35,696)</b>	<b>0</b>	<b>(5,041)</b>	<b>(54,412)</b>	<b>37,353</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(57,796)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(35,798)</b>	<b>0</b>	<b>1,030</b>	<b>(54,412)</b>	<b>44,301</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(44,879)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	(28,023)	93,730	1,325	0	1,130	0	0	0	0	0	0	68,162	30
31	Amortization of Pre-Op. & Org.	0	0	64	0	0	0	0	0	0	0	0	64	31
32	Interest	0	182,128	1,617	0	5,546	0	0	0	0	0	0	189,291	32
33	Real Estate Taxes	(15,975)	0	1,208	0	950	0	0	0	0	0	0	(13,817)	33
34	Rent-Facility & Grounds	0	(290,794)	0	0	0	0	0	0	0	0	0	(290,794)	34
35	Rent-Equipment & Vehicles	0	0	316	0	1,050	0	0	0	0	0	0	1,366	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(43,998)</b>	<b>(14,936)</b>	<b>4,530</b>	<b>0</b>	<b>8,676</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,728)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(79,796)</b>	<b>(14,936)</b>	<b>5,560</b>	<b>(54,412)</b>	<b>52,977</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(90,607)</b>	<b>45</b>

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780

Report Period Beginning:

1/01/08

Ending:

12/31/08

**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
		AVAILABLE UPON REQUEST		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				ROSE GARDEN CARE CENTER LLC, SKOKIE		REAL ESTATE
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					SKOKIE	

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 290,794	ROSE GARDEN CARE CENTER, LLC	100.00%	\$	\$ (290,794)	1
2	V	30 DEPRECIATION (SL)				88,640	88,640	2
3	V	32 INTEREST				181,206	181,206	3
4	V							4
5	V	10a THERAPY SERVICES	28,454	CAREPLUS REHABILITATIVE SERVICES	100.00%	28,454		5
6	V	30 DEPRECIATION				5,090	5,090	6
7	V	32 EQUIPMENT LOAN INTEREST				922	922	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 319,248			\$ 304,312	\$ * (14,936)	14

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER# 0041780Report Period Beginning: 1/01/08Ending: 12/31/08

## 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	17 Home Office	\$ 80,000	Platinum Health Care, LLC	100.00%	\$	\$ (80,000)	15	
16	V	5 Utilities		Platinum Health Care, LLC		2,801	2,801	16	
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		3,270	3,270	17	
18	V	17 Administrative Salary		Platinum Health Care, LLC		15,493	15,493	18	
19	V	19 Professional Fees		Platinum Health Care, LLC		3,652	3,652	19	
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		407	407	20	
21	V	21 Clerical Salaries		Platinum Health Care, LLC		37,154	37,154	21	
22	V	21 Office Expenses		Platinum Health Care, LLC		4,543	4,543	22	
23	V	24 Education & Seminars		Platinum Health Care, LLC		263	263	23	
24	V	25 Travel		Platinum Health Care, LLC		3,119	3,119	24	
25	V	26 Insurance		Platinum Health Care, LLC		426	426	25	
26	V	27 Employee Benefits		Platinum Health Care, LLC		9,902	9,902	26	
27	V	30 Depreciation		Platinum Health Care, LLC		385	385	27	
28	V	35 Equipment Rental		Platinum Health Care, LLC		316	316	28	
29	V	31 Amortization		Platinum Health Care, LLC		64	64	29	
30	V	30 Depreciation		Platinum Health Care, LLC		940	940	30	
31	V	32 Interest		Platinum Health Care, LLC		1,617	1,617	31	
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		1,208	1,208	32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 80,000			\$ 85,560	\$ *	5,560	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER# 0041780Report Period Beginning: 1/01/08Ending: 12/31/08

## 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	17 MANAGEMENT FEES	\$ 10,000	CAREPLUS MGMT INC	100.00%	\$	\$ (10,000)	15	
16	V	19 ADMIN CONSULT FEES	25,000				(25,000)	16	
17	V	19 DATA PROCESSING FEES	3,412				(3,412)	17	
18	V	21 CLERICAL FEES	16,000				(16,000)	18	
19	V							19	
20	V							20	
21	V							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		\$ 54,412			\$	0 \$ *	(54,412)	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	CAREPLUS MGMT INC	100.00%	\$ 11	\$ 11	15
16	V	6 MAINT & REPAIRS				1,125	1,125	16
17	V	6 MAINTENANCE SALARIES				796	796	17
18	V	7 SECURITY				5	5	18
19	V	10 NURSING SALARIES				4,303	4,303	19
20	V	10a THERAPY SALARIES				706	706	20
21	V	10a REHAB SUPPLIES				2	2	21
22	V	17 ADMIN SALARIES				13,898	13,898	22
23	V	19 PROFESSIONAL FEES				2,065	2,065	23
24	V	20 ADVERTISING				482	482	24
25	V	21 OFFICE EXPENSE				2,737	2,737	25
26	V	21 OFFICE SALARIES				9,546	9,546	26
27	V	23 SEMINARS				253	253	27
28	V	24 TRAVEL				9	9	28
29	V	25 TRANSPORTATION				1,507	1,507	29
30	V	26 INSURANCE				291	291	30
31	V	27 EMPLOYEE BENEFITS				6,565	6,565	31
32	V	30 DEPRECIATION				1,130	1,130	32
33	V	32 INTEREST				5,181	5,181	33
34	V	32 INTEREST TAG 18				332	332	34
35	V	32 INTEREST CP REHAB EQUIP				33	33	35
36	V	33 REAL ESTATE TAX TAG 18				950	950	36
37	V	35 EQUIPMENT RENT				1,050	1,050	37
38	V							38
39	Total		\$			\$ 52,977	\$ * 52,977	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENT # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

## 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	JAKOB BAKST	DIR OPERATIONS			AVAILABLE	0.9		SALARY	\$ 2,962	17-7	1
2	SHERWIN RAY	ADMIN CONSULT			UPON REQUEST	0.9		SALARY	2,962	17-7	2
3	ROSLYN INDICH	CONTROLLER A/P				0.9		SALARY	923	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,847		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.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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 Platinum Health Care, LLC  
 Street Address 7444 Long Ave.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847 ) 329-4100  
 Fax Number ( 847 ) 329-7652

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	5	Utilities	Patient Days	522,253	12	\$ 54,883	\$ 26,650	\$ 2,801	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	26,650	3,270	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	303,614	15,493	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	26,650	3,652	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	26,650	407	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	728,090	37,154	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	26,650	4,543	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	26,650	263	8
9	25	Travel	Patient Days	522,253	12	61,119	26,650	3,119	9
10	26	Insurance	Patient Days	522,253	12	8,354	26,650	426	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	26,650	9,902	11
12	30	Depreciation	Patient Days	522,253	12	7,547	26,650	385	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	26,650	316	13
14	31	Amortization	Patient Days	522,253	12	1,246	26,650	64	14
15	30	Depreciation	Patient Days	522,253	12	18,405	26,650	940	15
16	32	Interest	Patient Days	522,253	12	31,679	26,650	1,617	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	26,650	1,208	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,676,656	\$ 1,031,704	\$ 85,560	25

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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 CAREPLUS MGMT  
 Street Address 8320 SKOKIE BLVD  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847 )329-1555  
 Fax Number ( 847 )329-9555

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	5	UTILITIES	PATIENT DAYS	373,906	10	\$ 739	\$ 5,680	\$ 11	1
2	6	MAINT & REPAIRS	PATIENT DAYS	373,906	10	74,048	5,680	1,125	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	373,906	10	52,396	5,680	796	3
4	7	SECURITY	PATIENT DAYS	373,906	10	308	5,680	5	4
5	10	NURSING SALARIES	PATIENT DAYS	373,906	10	283,250	5,680	4,303	5
6	10a	THERAPY SALARIES	PATIENT DAYS	373,906	10	46,472	5,680	706	6
7	10a	REHAB SUPPLIES	PATIENT DAYS	373,906	10	120	5,680	2	7
8	17	ADMIN SALARIES	PATIENT DAYS	373,906	10	914,862	5,680	13,898	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	373,906	10	136,016	5,680	2,065	9
10	20	ADVERTISING	PATIENT DAYS	373,906	10	31,710	5,680	482	10
11	21	OFFICE EXPENSE	PATIENT DAYS	373,906	10	180,149	5,680	2,737	11
12	21	OFFICE SALARIES	PATIENT DAYS	373,906	10	628,409	5,680	9,546	12
13	23	SEMINARS	PATIENT DAYS	373,906	10	16,659	5,680	253	13
14	24	TRAVEL	PATIENT DAYS	373,906	10	612	5,680	9	14
15	25	TRANSPORTATION	PATIENT DAYS	373,906	10	99,225	5,680	1,507	15
16	26	INSURANCE	PATIENT DAYS	373,906	10	19,140	5,680	291	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	373,906	10	432,184	5,680	6,565	17
18	30	DEPRECIATION	PATIENT DAYS	373,906	10	74,281	5,680	1,130	18
19	32	INTEREST	PATIENT DAYS	373,906	10	341,048	5,680	5,181	19
20	32	INTEREST TAG 18	PATIENT DAYS	373,906	10	21,878	5,680	332	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	373,906	10	2,189	5,680	33	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	373,906	10	62,515	5,680	950	22
23	35	EQUIPMENT RENT	PATIENT DAYS	373,906	10	69,127	5,680	1,050	23
24									24
25	TOTALS				\$ 3,487,337	\$ 1,927,389		\$ 52,977	25

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTE # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	RELATED PARTY: ROSE GARDEN CARE CENTER, LLC									1										
2	AMCORE BANK		X	MORTGAGE						181,206	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	CAREPLUS MGMT	X		WORKING CAPITAL						9,283	6									
7	SHAREHOLDERS	X		WORKING CAPITAL						8,256	7									
8	FIRST BANK		X	LINE OF CREDIT						5,104	8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 203,849	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11	ALLOCATION FROM CP REHAB									922	11									
12	ALLOCATION FROM CP									5,546	12									
13	ALLOCATION FROM PLATINUM									1,617	13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 8,085	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 211,934	15									

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

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

\*\* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ROSE GARDEN CONVALESCENT CENTER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417 ) 865-8701 FAX #: ( 417 ) 865-0682

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

	(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>14-15-426-004</u>	<u>NURSING HOME</u>	\$ <u>49,582.98</u>	\$ <u>49,582.98</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>49,582.98</u>	\$ <u>49,582.98</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 ROSE GARDEN CONVALESCENT CENTER

# 0041780 Report Period Beginning:

1/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1 NO BASEMENT

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).

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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>400,860</u>	<u>1998</u>	<u>\$ 126,500</u>	1
2					2
3	<b>TOTALS</b>	<b>400,860</b>		<b>\$ 126,500</b>	<b>3</b>

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780

Report Period Beginning:

1/01/08

Ending:

12/31/08

**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	110		1998		\$ 2,536,069	\$ 65,025	39	\$ 65,025		\$ 669,245	4
5					884,255	23,615	39	23,615		293,813	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		CARE PLUS REHAB:									9
10		WATER HEATER		2004	10,051		39	258	258	1,511	10
11											11
12											12
13		SEWER LINE/FIRE RATED WALL		2005	16,205		27.5	589	589	2,036	13
14		TILE/CARPET		2005	2,583		27.5	94	94	326	14
15		SIDEWALKS		2006	3,700		15	247	247	618	15
16		SECURITY LOCKS/CAMERA SYSTEM		2006	11,010		27.5	400	400	984	16
17		GABLE WORK		2006	1,740		27.5	63	63	155	17
18		ROOFTOP AC & HEAT		2006	12,315		27.5	448	448	1,101	18
19		BATHROOM REMODEL		2006	2,950		27.5	107	107	263	19
20		ELECTRIC WORK		2006	2,575		27.5	94	94	231	20
21		THREE COMPARTMENT SINK & FAUCET		2006	2,000		27.5	73	73	179	21
22		TILE WORK IN KITCHEN		2006	6,862		27.5	250	250	615	22
23		GREASE TRAP		2006	3,900		27.5	142	142	207	23
24		ELECTRICAL WORK		2007	1,750		27.5	64	64	93	24
25		CABINETS/CLAY TILES		2007	1,793		27.5	65	65	95	25
26		EXHAUST WORK		2007	19,999		27.5	727	727	1,060	26
27		ANNUNCIATOR-NURSE STATION		2007	1,172		27.5	43	43	63	27
28						2,000			(2,000)		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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER

# 0041780

Report Period Beginning:

1/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	2008	4,095		5	614	614	614	38
39	2008	4,234		10	247	247	247	39
40	2008	1,500		10	88	88	88	40
41	2008	585		10	29	29	29	41
42	2008	3,600		40	38	38	38	42
43	2008	6,763		10	282	282	282	43
44	2008	751		10	6	6	6	44
45	2008	1,250		10	10	10	10	45
46	2008	3,364		10	28	28	28	46
47	2008	7,800		10	65	65	65	47
48	2008	1,860		10	16	16	16	48
49	2008	875		10	7	7	7	49
50			17,887			(17,887)		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			430		430			64
65								65
66			419		408	(11)		66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,557,606	\$ 109,376		\$ 94,572	\$ (14,804)	\$ 974,025	70

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	\$ 69,696	\$	\$ 6,970	\$ 6,970	10 yrs	\$ 38,083	71
72	Current Year Purchases	29,214	16,494	1,395	(15,099)	VAR	1,395	72
73	Fully Depreciated Assets	15,297						73
74	Related Party Allocation		1,606	1,606				74
75	TOTALS	\$ 114,207	\$ 18,100	\$ 9,971	\$ (8,129)		\$ 39,478	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,798,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,543	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,933)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,013,503	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 23,719 Description: Med equip \$4,760; Lndry equip.\$8,164; Ice/dish mach's. \$7,419; Copier \$2,320; Water Trtmt \$300; Misc 756  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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-3	hrs	\$		\$ 9,698	\$		\$ 9,698	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			1,242			1,242	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			11,921			11,921	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				67,721		67,721	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab &amp; X-ray</u>	39-3					3,136		3,136	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 22,861	\$ 70,857		\$ 93,718	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.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER# 0041780Report Period Beginning: 1/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (98,167)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,136,630		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,816		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,060,279	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	36,677		15
16	Equipment, at Historical Cost	29,214		16
17	Accumulated Depreciation (book methods)	(34,382)		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): <b>Option Deposit</b>	200,000		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 231,509	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,291,788	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 106,447	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	590,000		29
30	Accrued Salaries Payable	18,382		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Accrued Expenses</b>	16,400		36
37	<b>Due Others, Adv Billing</b>	448,397		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,229,626	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,229,626	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 62,162	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,291,788	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>102,492</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PRIOR OPERATOR</b>	<b>(40,330)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>62,162</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>62,162</b>	<b>24</b> *

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 1/01/08 Ending: 12/31/08

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,844,661	1
2	Discounts and Allowances for all Levels	(160,139)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,684,522	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	465,894	6
7	Oxygen	130	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 466,024	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,047	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,627	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 53,674	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc Income	47	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 47	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,204,267	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	778,868	31
32	Health Care	1,721,803	32
33	General Administration	1,034,920	33
<b>B. Capital Expense</b>			
34	Ownership	434,937	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	70,857	35
36	Provider Participation Fee	60,390	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,101,775	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	102,492	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 102,492	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. Tax Return on Cash Basis

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

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

Facility Name & ID Number **ROSE GARDEN CONVALESCENT CENTER**

# **0041780**

Report Period Beginning: **1/01/08**

Ending:

**12/31/08**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,986	2,174	\$ 69,440	\$ 31.94	1
2	Assistant Director of Nursing	2,188	2,413	64,457	26.71	2
3	Registered Nurses	10,327	11,086	290,689	26.22	3
4	Licensed Practical Nurses	13,897	15,889	348,724	21.95	4
5	CNAs & Orderlies	38,930	40,706	470,661	11.56	5
6	CNA Trainees					6
7	Licensed Therapist	482	592	35,945	60.72	7
8	Rehab/Therapy Aides	6,950	7,326	125,149	17.08	8
9	Activity Director	2,026	2,323	23,854	10.27	9
10	Activity Assistants	1,530	1,830	18,217	9.95	10
11	Social Service Workers	6,702	7,403	112,426	15.19	11
12	Dietician					12
13	Food Service Supervisor	1,966	2,130	35,726	16.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,189	16,948	135,231	7.98	15
16	Dishwashers					16
17	Maintenance Workers	3,340	3,678	55,801	15.17	17
18	Housekeepers	10,733	11,570	111,651	9.65	18
19	Laundry	5,904	7,149	64,356	9.00	19
20	Administrator	1,741	2,456	71,630	29.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,973	7,706	129,498	16.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,060	2,203	29,160	13.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,924	145,582	\$ 2,192,615 *	\$ 15.06	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	172	\$ 8,181	1-3	35
36	Medical Director	Monthly	10,100	9-3	36
37	Medical Records Consultant		1,695	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		285	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	4,118	12-3	45
46	Other(specify) <u>Psychiatric Cons</u>		5,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	\$ 29,379		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name &amp; ID Number ROSE GARDEN CONVALESCENT CENTER

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$7,150
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 0 Line
- (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.
- (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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,390  
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? N/A Indicate the amount. \$
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation. ATTACHED
- 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?
- 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:          The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?          If no, please explain.
- (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.